







# Harvard Medical

ALUMNI BULLETIN SPRING 1997



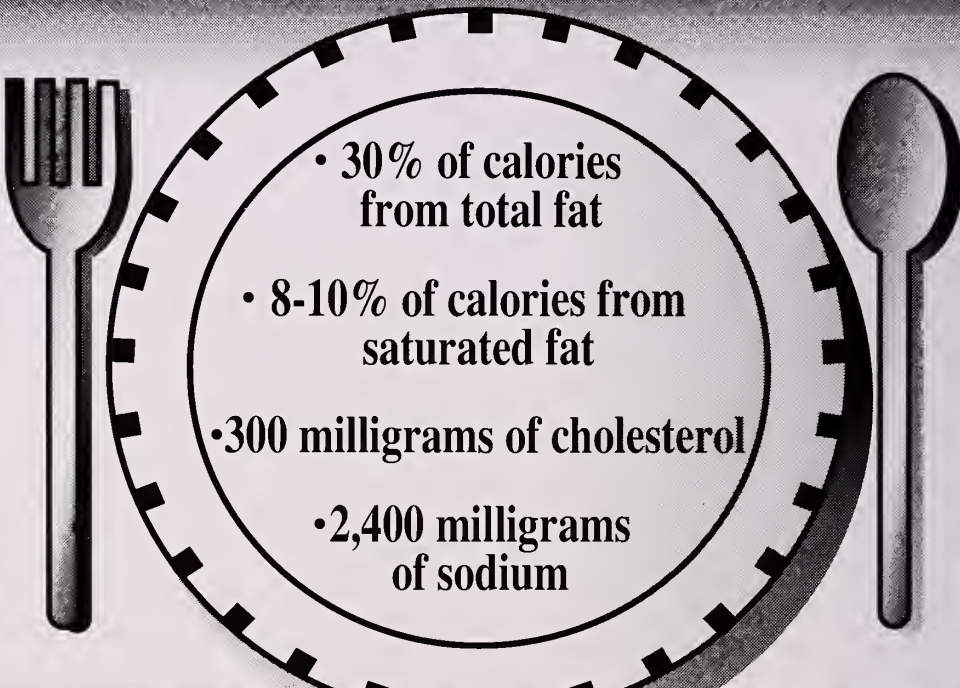
**Access for All**



# Guidelines for Healthful Eating

American Heart Association<sup>SM</sup>  
Fighting Heart Disease and Stroke

*The American Heart Association says – that on average – your daily diet should not include more than:*

- 
- 30% of calories from total fat
  - 8-10% of calories from saturated fat
  - 300 milligrams of cholesterol
  - 2,400 milligrams of sodium

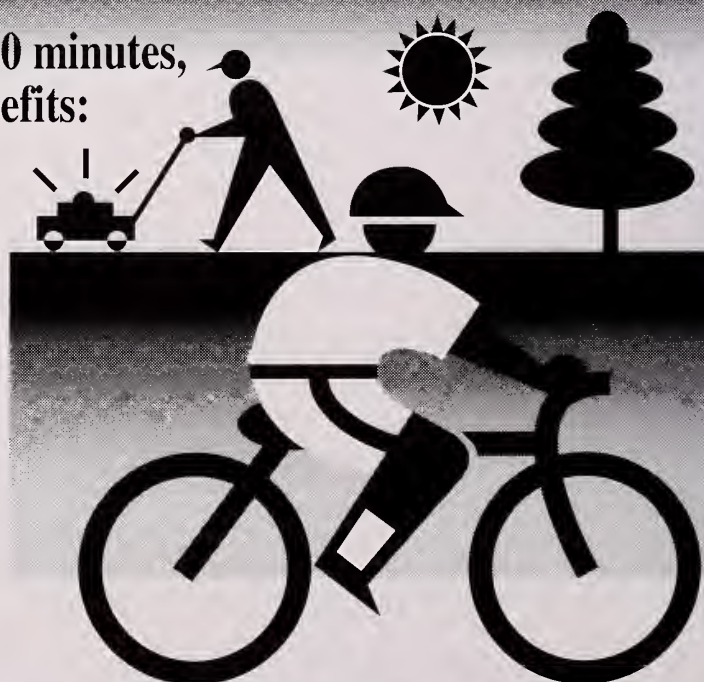
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# Get in on the Action

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Vigorous activities done for 30-60 minutes, 3-4 times weekly, offer these benefits:

- Improves circulation
- Controls weight
- Prevents and manages high blood pressure
- Lowers blood cholesterol levels
- Raises HDL-cholesterol levels
- Boosts energy levels



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# Harvard Medical

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The Family Van. Photo by  
Stuart Darsch

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"Who loses and who wins; who's in, who's out..." That, to borrow the line from Lear, is the central problem of medicine as the half century of its greatest triumph comes to a close.

Franklin Roosevelt had no access to either the immunization that would have prevented his poliomyelitis or the drugs that could have lowered his blood pressure and prevented his fatal stroke in 1945. The best that he could afford, with his considerable fortune, gave him relatively little medical advantage over the poorest of Americans at the depth of the Great Depression. Since he died, polio has been all but eliminated in developed countries and the morbidity and mortality from strokes substantially reduced.

Saving lives, however, has not saved money. Indeed, improved technology has been a driving force behind the rising costs of health care. People are living longer. Paradoxically, the triumph of effective medicine bids has made it a yet scarcer resource, not a more plentiful one. Who then is to have access to medical care?

In this issue of *HMAB* we look at the problem of access from various angles. Ellen Barlow, editor of the *Bulletin*, brings us up to date on the mergers among Harvard hospitals; institutions that once seemed as stable as tectonic plates have been crashing into each other, making familiar boundaries obscure. Traveling to the medical antipodes, Boston's poorest neighborhoods, Janet Walzer, our associate editor, describes an effort to breach barriers to access that are more than monetary. Far from the inner city, Daniel Doyle '72 reports on efforts to provide health care in Appalachia.

Arnold Epstein, from the vantage point of an eyewitness to the Clinton's efforts at forging a new national health policy, analyzes the course of events since then, and warily ventures some predictions about the next phase. Jordan Cohen '60, president of the Association of American Medical Colleges, explains why training minority students improves the care of the underserved. Harvey Makadon explores the legacy of AIDS and the lessons we have learned. And Joshua Sharfstein '96 looks at merger mania through a student's glass—darkly.

*William Ira Bennett '68*

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# Letters

## Patient Suffering

On page 31 of the Winter issue, Linda Emanuel is quoted as stating: "I have never seen a case of patient suffering that could not be handled by aggressive palliative care."

While I am not familiar with the range of Dr. Emanuel's clinical experience, I would call her attention to the plight of men with advanced prostatic cancer and multiple bone metastases with frequent pathological fractures. Some are produced merely by turning over in bed. Do not forget that a pathological fracture is just as painful as a fracture in normal bone. The same is true of some women with late breast cancer.

Some burn patients come to mind, especially young adults with terrible gasoline burns from automobile accidents, around the head, shoulders, face, often obliterating all the features of the face. As these third-degree burns separate and slough, left behind is a granulating surface richly innervated by all the nerves of the normal face. Here is suffering not relieved by any means we have except early skin grafting, though assuredly not an invitation to assisted suicide.

These and other examples come to mind in relation to Emanuel's rather sweeping and unrealistic statement. Don't forget that "snowing" patients with repeated massive doses of morphine produces severe constipation and obstipation, fecal impaction, and sometimes rupture of the sigmoid. Cordotomy and frontal lobotomy can sometimes be used, but are terribly disabling.

Although assisted suicide might become a refuge only in very rare cases, it is totally unrealistic to state that current conventional palliative methods will take care of all forms of human agony.

Frances D. Moore '39

## Remembering Denny-Brown

The Winter issue of the *Bulletin* was superb and I particularly enjoyed the article by Sid Shulman and Joel Vilensky about Denny-Brown. It was so characteristic and well done, and it recalled my own memories of Denny-Brown.

He and I were separated by thousands of miles, he in India and I in New Guinea in World War II, but after the war I became a neurosurgeon and was appointed to the Board of Scientific Counselors of the National Institute of Neurological Diseases and Blindness, of which he was a member. It was a genuine education to be with him and he was a clearly frank and outspoken person. On one occasion when we were talking to the director, he was exasperated and said, "What I don't understand is what this neurological institute is doing here anyway." He was talking about the huge clinical research center at the NIH.

Harvard has had outstanding people in neurology all these years, particularly with Houston Merritt and Bronson Crothers in children's neurology.

Eben Alexander '39

## One of the Best

Sissela Bok's article in the recent *Bulletin* was one of the best I've read on the subject. I happen to be in the middle of her book *Lying*, which I am also enjoying.

Richard Wilson '76

## The Ultimate Connection

Thank you so much for another excellent issue of the *Bulletin*. I particularly enjoyed "Death on the Streets" by my classmate Jim O'Connell. It was a fine, heartfelt and moving piece of writing.

"My Patients, My Self" is such a timely article. In the emergency department I see patients at or near the end of life every week. It is so good to see that HMS is offering a course to help developing physicians learn the essential need these folks and their families have for acknowledging their experience. They are living examples of the human condition and the ultimate connection our inevitable mortality gives us all.

Charles Hartness '82

## Dual Degrees

I have always enjoyed saving my copies of the *Harvard Medical Alumni Bulletin*, for I have found there has been a great advantage in re-examining and re-reading the articles over time.

The other day I chanced to read David A. Shaywitz's article, "The Physician-Scientist: Dual or Dueling Degrees?" which appeared in the Summer 1995 issue. I came upon the following statement: "Doing both science and medicine well is possible in certain fields, less achievable in others," agrees Stuart Lipton, a neurologist and neurobiologist at Harvard Medical School. "It would be very difficult in neurosurgery; for example, if you're choosing a surgeon, you want one who operates at least every other day. In medicine, while you need an intense initial training, it is not necessary to be in clinic every day."

I cannot disagree more with Dr. Lipton's belief that a neurosurgeon cannot simultaneously be both a laboratory scientist and an accomplished surgeon. I have spent over 40 years involved in both surgery and investiga-



tion of the central nervous system. There are many other neurosurgeons who have contributed to both the clinical and the experimental fields during the last few decades. This is true not only of neurosurgeons but other fields of surgery, and while we are on the subject, we should not forget the surgeons (although no neurosurgeons) who have received the Nobel Prize in Medicine or Physiology.

Sorry to be so late in my response, but perhaps a good article is like wine in that with time it only becomes better!

Robert J. White '53

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## Gender Makes a Difference

Although differences in how men and women communicate might not be a new story, what is new is how these differences can affect patient care. For example, women physicians spend close to 13 percent more time with their patients than their male counterparts. This is one of the findings reported by Lucy Candib '72 in her December talk as part of the Cabot Primary Care Series.

Candib, professor of family and community medicine at University of Massachusetts, reviewed data from several studies, including the National Ambulatory Care Survey. In a study performed at 11 ambulatory care sites and small group practices it was found that women physicians spent an average of 22.9 minutes with their patients as opposed to men physicians who spent 20.3 minutes. Interestingly, women spent more time with their female patients (23.3 minutes versus 22.3 minutes) and men physicians spent more time with their male patients (21.5 minutes versus 19.4 minutes).

One way this additional time by women physicians is used is on screening and prevention, says Candib. In a study of colorectal cancer surveillance at George Washington University Medical Center, 37.9 percent of women's patients were tested for fecal occult blood as opposed to 27.5 percent of men's patients. Women physicians also performed more sigmoidoscopies (37.9 percent) than men physicians (23.3 percent).

In a smaller study of family practice residents female residents were more likely than men residents to do screening tests such as mammograms, pelvic exams and Pap smears. Similarly, in a larger study of 25,000 women patients in Minnesota, it was found that women physicians were doing more Pap

smears than men physicians.

Although Candib acknowledged that some data in these studies were inconsistent, she pointed out that an "increased tendency to screen our own gender seems to emerge as a relatively consistent effect."

Candib, who is also a family physician in Worcester and author of *Medicine and the Family: A Feminist Perspective*, noted that studies also demonstrate that women physicians talk to their patients more than men physicians. And in return, "Women physicians get a whole lot more information back from patients," observes Candib.

Yet Candib does not believe that communication is "inherently gender based." Physicians can learn communication skills, says Candib. She advises doctors to reflect on how gender influences their practices. "We do have a choice about how we communicate with others."





Dennis Selkoe

### Protein Culprit in Alzheimer's Disease

Researchers used to believe that tangles and plaques—the hallmarks of Alzheimer's disease—were just artifacts of the disease but not the direct cause. This may well be true for tangles, but new evidence that builds on his work reported four years ago has convinced Dennis Selkoe, HMS professor of neurology at Brigham and Women's Hospital, that plaques are in fact a major cause of the disease.

Four years ago Selkoe and colleagues found that even normal human brain cells produce amyloid beta protein (A beta), the protein found in plaques. This raised the possibility that Alzheimer's disease might actually be a direct consequence of an overproduction of A beta.

Now, Selkoe and collaborators in his and other laboratories have additional evidence that this is the major causal mechanism. They reported in the January 1997 *Nature Medicine* that when two mutant Alzheimer's genes, presenilin 1 and presenilin 2, were transfected into normal human kidney cells, production of a particular form of A beta (A beta 42) doubled.

"Given that this occurs directly in cultured cells in the absence of the disease state, it's clear the doubling is not a secondary effect," says Selkoe.

These findings come on the heels of an earlier discovery by Selkoe and Cynthia Lemere, HMS instructor in neurology, that Alzheimer's patients with mutant presenilin 1 genes have double the usual level of plaques containing A beta 42 in their brains. They reported these results in the August 1996 issue of *Nature Medicine*.

If overproduction of A beta 42 is a cause of some forms of Alzheimer's disease, as Selkoe believes, then one strategy for fighting the disease would be to selectively turn down production of the protein. Martin Citron and Selkoe reported in the November 1996 *Proceedings of the National Academy of Sciences* that such a strategy has been found to work for the other form of A beta, A beta 40. (A beta comes in two lengths, A beta 40 and A beta 42, which differ by just two amino acids.)

Ultimately, Selkoe and his colleagues hope to prevent Alzheimer's disease as well as treat it. "My vision is that as part of a health screening ten

years from now, you'll have your blood level of A beta 40 and A beta 42 checked," he says. He speculates that clinical trials of A beta blockers could perhaps begin as early as 1999, and that in ten years, "doctors could have a whole armamentarium of anti-Alzheimer's drugs even beyond these."

Selkoe's colleagues (left to right): Cynthia Lemere, Sayeon Kim, Martin Citron, Weeming Xia and Thelka Diehl



## John Schott, M.D.

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### Beta Blockers Can Save Lives

Elderly patients who take beta blockers after surviving heart attacks have 43 percent less chance of dying in the two years post attack than those who do not take the drug. Such are the findings reported by Harvard researchers in the January 8, 1997 issue of the *Journal of the American Medical Association*.

The study, led by Stephen B. Soumerai, associate professor of ambulatory care and prevention at HMS and Harvard Pilgrim Health Care, is the first of its kind to examine the use of beta blockers in heart attack patients over the age of 65. Indeed, patients over the age of 75 have never been included in previously randomized trials studying the protective effects of beta blockers, says Soumerai. "This is remarkable. We're talking about a very at-risk population."

Only one in five patients are actually given beta blockers after heart attacks. This underuse could be deadly, as Soumerai estimates that thousands of lives might be saved by beta blockers. Although it is not clear why beta blockers are underused, the authors hypothesize that physicians still have concerns about potential side effects, such as depression and heart failure. Yet the data on beta blocker effectiveness is so convincing that Soumerai says, "Some physicians joke that we should put them in the water supply."

The federally funded study examined 5,332 Medicare patients in New Jersey between 1987 and 1992, of whom 3,737 were deemed eligible for beta blocker use. These patients, however, were three times more likely to receive calcium-channel blockers, a much costlier drug and not as effective. The use of calcium-channel blockers placed these patients at twice the risk of death because they were substituted for beta blockers.

Soumerai's coauthors are Thomas McLaughlin of HMS and HPHC, Donna Spiegelman and Ellen Hertzmark of HSHP, George Thibault '69 of HMS and Brigham and Women's Hospital and Lee Goldman of UCSF.

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E. Murray '43B and  
Francis D. Moore '39.

### An Historic Unveiling

More than 50 people gathered at the Countway Library on December 20, 1996, for the unveiling of the painting that commemorates the first successful human organ transplantation. Members of the historic transplant team, Leroy D. Vandam, professor emeritus of anesthesia, Joseph E. Murray, professor emeritus of surgery, and Francis D. Moore, Moseley Professor Emeritus of Surgery, commissioned the painting from Joel Babb,

of Buckfield, Maine, and donated it to Harvard University. Dean Tosteson accepted the work on Harvard's behalf at the event. The portrait depicts the operation as it was being carried out at the Peter Bent Brigham hospital on December 23, 1954. The painting now hangs in the library's main lobby, across from the Robert Hinckley painting, "First Operation Under Ether."



## MD-PhD Alumni Survey Results

A recent survey conducted by Harvard's MD-PhD program indicates that no one should be disappointed in the accomplishments of these dual-degree recipients.

In 1964 the NIH established the first medical scientist training program (MSTP) to offer the combined MD-PhD degree. It was hoped that these physician-scientists would become tomorrow's leaders in scholarship, teaching and research. With Harvard established as one of the largest programs in the country (150 in the current MD-PhD class), there are now 33 of these programs nationally, supported in large part by the NIH.

Survey results of HMS MD-PhD alumni indicate that of the 107 men and women who have finished their

postdoctoral training, there are two NIH chiefs, nine full professors, 24 associate professors, 50 assistant professors and nine instructors. Currently there are nine graduates who work in industry: two CEOs, two vice presidents, two division directors and three senior research scientists. While 87 individuals are still completing their residencies and fellowships, two are in private practice. The highest number of graduates are in departments of medicine (64), followed by 16 graduates in surgery, 14 in pathology, 14 in pediatrics, 12 in neurology and 12 in neurosurgery.

An overwhelming majority of those surveyed (96 percent) believe that their dual-degree training was important to their careers, although a smaller number believed that either an

MD or a PhD would have been adequate for their careers. And 40 percent of respondents noted that their careers have been what they expected when they first entered the MD-PhD program.



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### FRIDAY, SEPTEMBER 5

#### Opening Session: 8:30 a.m.

**Andrew G. Wallace**, Dean, Dartmouth Medical School

**James O. Freedman**, President, Dartmouth College

**Joseph L. Goldstein**, Cochair, Bicentennial Symposium

#### Genetics: 10:00 a.m.

**David Botstein**, Chair, Department of Genetics, Stanford

**Richard Axel**, Professor of Biochemistry, Columbia

**Francis Collins**, Director, National Human Genome Institute

**Nancy Wexler**, Hereditary Disease Foundation

#### Neuroscience: 2:30 p.m.

**Pasko T. Rakic**, Chair of Neurobiology, Yale

**Gerald Edelman**, Nobel Laureate, Scripps Research Institute

**Marcus E. Raichle**, Neurologist, Washington University

**Steven Pinker**, Cognitive Scientist, MIT

### SATURDAY, SEPTEMBER 6

#### Health Care: 9:30 a.m.

**Susan G. Dentzer**, Senior Writer, *U.S. News & World Report*

**C. Everett Koop**, Senior Scholar, Koop Institute at Dartmouth

**Philip Kitcher**, Professor of Philosophy, UCSD

**Daniel J. Callahan**, Director, Hastings Institute

**Lonnie R. Bristow**, Immediate Past President, AMA

**Ruth Purtilo**, Director, Center for Health Policy and Ethics, Creighton University

**William Roper**, Senior Vice President, Prudential HealthCare

**Robert G. Evans**, Economist, University of British Columbia

#### World Population: 2:30 p.m.

**Michael S. Teitelbaum**, Program Officer, Sloan Foundation

**Thomas Homer-Dixon**, University of Toronto

**Hania Zlotnik**, Chief, Mortality and Migration, United Nations

#### Bicentennial Concert: 8:00 p.m.

Varied program, including a special bicentennial commission

### SUNDAY, SEPTEMBER 7

#### Closing Session: 9:30 a.m.

**S. Marsh Tenney**, Professor of Physiology Emeritus, Dartmouth

**Sir David Weatherall**, Professor of Medicine, Oxford University

**Michael S. Brown**, Cochair, Bicentennial Symposium

**Heinz Valtin**, Chair, Bicentennial Symposium Committee



# Commentary

by Victoria McEvoy

I open the recent batch of patient complaints from one of our HMOs: Mrs. Quill is furious because her primary care doctor won't authorize a breast reduction with the plastic surgeon that her best friend used. John Bellow wants the HMO to pay for his son's orthotics, despite the fact that orthotics are not a covered benefit. If the HMO doesn't agree to pay, he will sue for malpractice since the injury was never treated properly in the first place. Mary Gold is going to switch doctors because she called her doctor one morning and never got a call back. The doctor explains that he never received the message.

I put aside my medical director hat and put on my pediatrician hat. "I'll deal with those later." Looking forward to greeting a cherubic three-year-old clutching a Barbie doll with no hair, I happily resume the role of doctor. Thirty minutes later I am locked in a battle with the three-year-old's mother who insists that amoxicillin is the wrong drug.

Some days as the medical director of a busy multispecialty group practice I feel I am on the field of a Chechen war zone—tentatively stepping out to take care of patients, deciding that all is well, only to be broadsided by another missile from an edgy consumer. Most of us welcome educated patients who take responsibility for their health care, but consumerism is a double-edged sword.

Some days are great, filled with satisfying patient interactions: a new diabetic who feels better on insulin, a wound that finally heals, or a chocolate-stained drawing from a little patient who used to cry whenever my visage appeared. Other days calls are placed to real estate licensing boards inquiring how to get a license or to benefit offices inquiring how long until pensions can sustain early retirement.

The daily papers mirror this love-hate, manic-depressive roller coaster that the doctor-patient relationship rides as we descend deeper and deeper into managed care hell. Hillary's plan is starting to look better every day.

But perhaps it is not surprising that patients enter our offices with a skeptical chip on their shoulders. If I believed all that I read I would enter an exam room cautiously as well. A recent salvo in the *New York Times* from Stephen Cohen (10/10/96) is entitled "Should Health Care Come with a Warranty?" After jokingly suggesting that doctors should offer money-back guarantees for less than satisfying results, he points out that perhaps financial incentives should be aligned with compassion, kindness and dedication. Has it really come to this? Do consumers think that without financial reward, we will not be kind?

In an era when patients can now "check up" on doctors in the data bank by "1-800 let's see if she has a record," it is hard not to feel that a line in the sand has been drawn. If we were privy to the "records" of lawyers, plumbers, financial analysts, real estate brokers and administrators, doctors would not feel so besieged. At times it seems that the rights accorded to patients are not available to health care providers. While patients can complain to patient advocates, investigate a doctor's past, and dump a doctor on the spur of the moment, doctors cannot even sever the patient-doctor bond because of contractual obligations to HMOs. So doctors can be mistreated by their patients with no recourse.

While the pool of people who feel sorry for doctors is vanishingly small, we certainly are entitled to a brief moment of silence to remember the once sacrosanct doctor-patient relationship. What can be done to rescue the core of goodness that prompted

most of us to pursue a life in the healing professions?

First we need to remember that this is not a fight with doctors and patients in separate corners. We are on the same team, pursuing the same goal, and actually have more in common than we recognize. Both patients and doctors feel the burn of managed care.

Next we must acknowledge that the fee-for-service system was not the altruistic, trouble-free machine that we like to memorialize. But the baby is getting tossed out with the bath water. We've got to be pointedly vocal about what we're at risk of losing. Long-term personal relationships with patients have been supplanted by revolving door patient panels tainted by battles over referrals and HMO rules. We need to get some control back. We can't let hostile articles go unanswered. We need to show that we can manage care in a fiscally and qualitatively sound way.

We all—doctors and patients—need to be part of the solution. Physicians must not cede their place at the table to administrators and politicians, and patients should remember that most physicians went to medical school to become healers. And both sides need to renew that special bond that takes place in the exam room without the HMO preferred drug formulary, the POS machine, and the bevy of health care consultants that are poisoning the sacred trust.

*Victoria McEvoy is the medical director of General Medical Associates in Weston, Massachusetts, HMS instructor in pediatrics and a member of the Bulletin editorial board.*



## Book Mark

THE EYE OF THE ARTIST  
by Michael F. Marmor and  
James G. Ravin  
(Mosby, St. Louis, 1997)

by Judith and John Dowling

This delightful and informative book is written primarily by two ophthalmologists, Michael F. Marmor '66, professor of ophthalmology at Stanford University, and James G. Ravin, clinical associate professor of the Medical College of Ohio. The book derives in good measure from two courses the authors have taught for a number of years at the annual meeting of the Academy of Ophthalmology. One course focuses on vision and art and the other on eye diseases in artists. Here they join forces, and with four collaborators—Christine A. Kenyon of the History of Art Department, University of Michigan; Philippe Lanthony of the Centre Hospitalier National d'Ophthalmologie des Quinze-Vingts in Paris; Jody Maxmin of the Stanford Department of Art; and Robert Weale of the University of London—they provide a wonderful overview of the role of visual function in art and how eye diseases and the aging eye might (and we emphasize might) have affected the work of an artist.

Were El Greco's elongated and ethereal figures the result of an eye astigmatism as has long been suggested? How did Monet's cataracts affect the coloring in his later paintings? Is there too much blue in his famous water lily paintings because his yellow lens was absorbing blue light excessively? The book addresses these and many other fascinating questions, and we won't give away the answers to these medical whodunits. We recommend enthusiastically that the interested reader pick up the book and

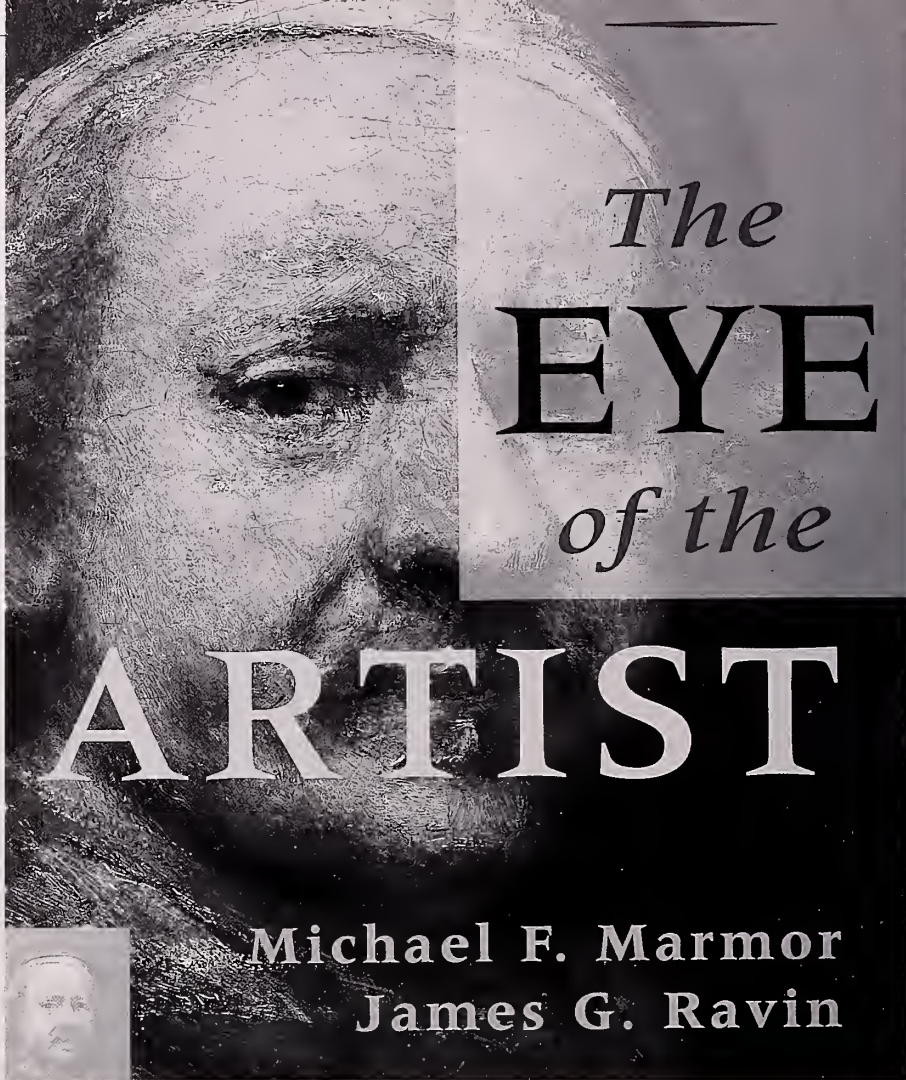
learn the answers for themselves, which are not always straightforward!

The book is divided into six parts. The first two chapters provide a very readable introduction to anatomy and physiology of the eye, retina and visual system. They also provide an overview of the main themes of the book—color and contrast in art, for example, and the effects on the artist of obvious eye deficits, especially those observed in the aging eye, including presbyopia (far-sightedness), cataracts and color deficiency. The other parts of the book focus in more detail on one of the themes set forth in Part I, and most of the chapters describe in some detail the work and eye problems of a prominent artist. Part II is entitled "The Problem of Focus" and its three chapters are devoted to Renoir, El Greco and Euphronios. The latter artist

may be unfamiliar to many: he was a pioneer in red-figure painting in Greece, working about 500 B.C.

Part III discusses "Light Versus Dark" and describes how border enhancement—the Mach Band phenomenon—has been used throughout the ages, particularly by Asian artists, to increase contrast, lightness and darkness in a painting. The second chapter in this section argues that the light in which a painting was painted is as critical as the light in which it is viewed, and they must be consonant.

Part IV focuses on color and its four chapters emphasize the work of four artists—Turner, Meryon, van Gogh and Seurat. Charles Meryon is another artist perhaps unfamiliar to many. He had a color vision defect—probably protanopia or deuteranopia (red or green blindness)—which he recog-





nized early in his career and caused him to give up oil painting and turn to etching. Part V, on "Perspective and Illusion," presents two essays: one on perspective and its use, or lack of use, through the ages, and the second on illusions and optical or op art. That visual perception is reconstructive and creative has long been recognized. Artists, particularly the op art artists and of course M.C. Escher, have long taken advantage of this phenomenon, i.e., what we perceive is based on imperfect information transmitted from the eye to the brain. Using this information and visual memories, our brains try to construct a coherent and logical precept. But the visual system can be confounded, as happens with visual illusions, and many artists have explored these effects.

The final section is the longest of the book. It consists of six chapters, each one devoted to a single artist: Monet, Cassatt, Pissarro, Degas, Munch and O'Keeffe. These chapters provide medical histories of the artists, particularly their ophthalmic histories, and the treatments then available to deal with their problems. It further describes the success of the therapies (or lack thereof), and the apparent effects of their maladies on their art, with an emphasis on how their works changed over the years as they aged or experienced eye diseases.

The book is lavishly illustrated with 190 figures, 120 of which are in full color. The reproductions are excellent and the publisher should be complimented on the quality of the reproductions and the book in general.

One of the great strengths of the book is the discussion throughout of many visual and psychological phenomena. The reader is introduced in a clear fashion to current ideas on color blindness, retinal and cortical processing of visual information, color mix-

ing, perspective, visual texture, visual illusions and, of course, Mach Bands. An entire chapter, as well as considerable discussion in one of the introductory chapters, is devoted to Mach Bands and not only is it shown clearly how artists over the ages have employed this phenomenon to enhance edges and borders, but also how Renoir purposely diminished contrast along the borders of his figures to soften his images.

The Mach Band phenomenon is attributed to Ernst Mach, the 19th century philosopher and psychologist, but this effect was known long before Mach's time. Leonardo da Vinci described the phenomenon very clearly in the 16th century: "The border of a vertical rod will appear very dark against a white field, and against a dark background it will appear brighter than any part of the rod, even though the light striking the latter is equally bright all along" (see R. Weale, *Discovery of Mach Band, Investigative Ophthalmology and Visual Science*, 18, 652-654, 1979). And, of course, Chinese painters exploited Mach Bands in their brush paintings some 1,300 years before da Vinci, beginning in the second century A.D.

Other aspects of considerable interest are pertinent historical anecdotes sprinkled throughout. In the chapter on Turner and his use of color is a description of Goethe's views on color and the fact that Goethe—a contemporary of Turner's—debunked Newton's views proposed nearly a century before that white light is a mixture of all colors and that light is corpuscular. Goethe wrote a book on color called *Theory of Colours* that is largely forgotten today, but Turner owned this book, made numerous notes in it, and was undoubtedly influenced by it.

As we age, many changes take

place, not only in our ability to see well, but to carry out skilled tasks. Artists are not exempt from these changes and an important theme in the book is how the works of a particular artist vary over time. How much of such change can be attributed to age and how much to an evolution of style? In some cases, aging effects can be claimed—coarser brush strokes, color abnormalities, and a lack of detail in a work. And sometimes, severe visual defects have led artists to alter the way they worked or even the medium in which they worked. As Georgia O'Keeffe lost her high acuity vision, probably because of macular degeneration, she employed a surrogate to help paint her pictures. Later she left painting altogether and turned to sculpture. Matisse turned to paper cutouts when his vision failed to the point that he could not paint and Degas, like O'Keeffe, turned to sculpture.

In sum, this book is a gold mine of fascinating historical and medical information, and it provides superb insights into the works of a number of the world's famous artists. For anyone interested in vision and art, this book is a must.

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# On the Road to Reform

by Arnold Epstein



AP Photo/Carlos Osorio

The federal failure to reform the health care system merely transferred responsibility to the private sector and the states.

JUST OVER FOUR YEARS AGO SOME 500 federal health care bureaucrats and private sector health care experts filed into the Executive Office Building in Washington, DC and began a three-month sprint to develop federal legislation that aimed at comprehensive health reform. Their goal was to establish universal coverage for all Americans and drastically revamp a health care system that had grown to encompass one-seventh of our economy. That effort and the long congressional struggle that ensued came to naught. Yet its final demise 20 months later did not signal the triumph of the status quo, but rather a new era of health reform orchestrated by the private sector and the states.

Everyone should be able to recall the horrors painted by opponents of national health reform during the media campaign of 1993 and 1994. If reform legislation passed, fee-for-service medicine would die. All Americans would be forced to enroll in HMOs and other variants of managed care. Free choice of provider would become a relic of the past, and rationing and restricted benefits would become commonplace.

Sponsors of health reform had an alternative set of predictions, no less dire. Without federal legislation, the number of uninsured individuals would grow inexorably. Medical cost escalation would increase to the point that it would threaten the competitive ability of American business. Medicare and Medicaid would drain federal and state budgets to the point of insolvency.

Today we still cannot assess the ultimate results of private health care reform. But already there have been enough changes to describe its character and predict its path.

## Competition and Consolidation

Many of the changes feared by Harry and Louise and their counterparts sitting around America's dinner tables have already come to fruition. Most Americans are facing a reduced choice



of health plan and practitioner. Among medium-sized employers, more than half are offering their workers only one health plan. According to a recent KPMG Peat Marwick/Wayne State University survey, nearly three-quarters of American workers are now enrolled in managed care plans, up from 51 percent in 1993.

The characteristics of managed care organizations, which provide care to most Americans, have also changed. For-profit managed care organizations now account for the majority of the managed care market, whereas a decade ago they enrolled just over 25 percent.

Competition has also had a large impact on hospitals and practitioners. Many hospitals across the country have closed or consolidated. More than half the nation's hospitals are now part of multi-hospital firms. The consolidation in Boston that created Partners HealthCare System and produced the merger between the Beth Israel Hospital and Deaconess Hospital is mirrored across Massachusetts where, according to the Massachusetts Health Data Consortium, the number of hospitals has decreased from 95 in 1992 to 84 today. Acute-care hospital patient days dropped from 5.5 million in 1992 to 4.3 million in 1995.

Ironically, physicians have been both embattled by managed care and increasingly involved in its management. Selective contracting by managed care plans, termination of physicians' contracts for economic rather than clinical reasons, and "gag rules"—contractual requirements that forbid physicians from advocating treatments for which the HMO will not approve payment, or from disclosing payments they may receive as a consequence of denying services to their patients—have been strongly opposed by individual physicians and their professional associations.

At the same time, physician-sponsored organizations (PSOs) have become a major weapon of organized

medicine. PSOs, which might be likened to the service arm of an HMO, can provide comprehensive medical services and contract directly with employers, eliminating the HMO middleman. Three-quarters of the 50 state medical societies are now planning to establish physician-sponsored organizations, reported Thomas Bodenheimer '65 in the November 21, 1996 issue of the *New England Journal of Medicine*.

One healthy byproduct of the more competitive marketplace has been the disruption of dramatic medical cost inflation that went unabated for many years. Between 1985 and 1991, for example, national health care expenditure increased at a fairly steady rate, averaging 10.1 percent annually, whereas in 1993 and 1994, the rate of increase dropped to 7 percent and then 6.4 percent.

The changes in the private sector have been even more dramatic. According to a recent national survey of employees with ten or more workers by Fouter Higgins, a benefits consulting firm in New York, health benefit costs increased only 2.1 percent in 1995, after a decline of 1.1 percent in 1994. Between 1988 and 1992 employees' health benefit costs increased nearly 15 percent annually.

Many economists believe that this change in inflationary trends could never have been achieved by the federal government. Decisions to close health care facilities are particularly difficult to legislate because of entrenched political interests, not to mention a general mistrust of government among Americans. Consider the special legislative rules developed to govern the closing of military bases. Closing hospital facilities would likely be even more difficult. Employers and other large purchasers are able to insist on changes that elected officials could never even propose.

Of course, reduced cost inflation in and of itself is not a universal blessing. Certainly lower rates of increase in medical costs are a boon for American

business. But although the hospital sector is in the midst of radical reengineering, thus far hospital margins have remained at or above historic levels.

Physicians' incomes, on the other hand, have declined. National data from the American Medical Association showed a decrease in physicians' incomes in 1994, breaking a long-term trend. Physicians' average net income had been rising steadily during the last decade except for a one-year break in 1990. Average earnings increased from \$154,800 in 1985 (1994 dollars) to \$195,300 in 1993 before falling nearly \$9,000 to \$186,600. Data from California, where the transition to managed care is among the most advanced, show even larger reductions in some doctors' earnings. Many predict that these trends will become even more pronounced as managed care changes patterns of use for medical services and a glut in specialists develops.

### **The HMO Backlash**

Some who decry the recent changes in the medical delivery system believe that we have adopted the Clinton vision of managed care but without consumer protections. Regulation of HMOs is largely state based. Consumer protections have traditionally been weak. The regulations for HMOs originally adopted in most states focused on assuring fiscal stability and basic minimal protections, such as appeals procedures. Most of the rules were developed over a decade ago when HMOs cared for a much smaller proportion of the population and the large majority of HMOs were not-for-profit organizations that were much less aggressive and threatening than today's highly competitive managed care organizations.

Now a backlash is spreading across the country. Physicians decry their loss of autonomy as well as the paperwork and rules that impede them from providing care efficiently. Patients fear that financial disincentives to providing needed medical services will

reduce quality of care in managed care organizations. The emergence of PSOs, the frequent reporting of HMO horror stories in the lay press, and the adoption of a wide range of new state and federal legislation are all evidence of this backlash.

In 1996 alone, more than 30 states passed legislation to regulate HMOs and strengthen consumer protections. Prohibitions against “gag rules,” guarantees of self-referral to specialists (most often gynecologists), and requirements for HMOs to pay for emergency care on the basis of a “prudent layperson’s” definition of a medical emergency (a definition much broader than that used by most HMOs) are among the most common sorts of regulatory relief. Perhaps the most controversial legislation passed both by the federal government and the majority of states is the prohibition of so-called “drive-by deliveries,” a law that requires HMOs to cover the cost of at least 48 hours of postpartum hospital care.

#### **Changes in Quality of Care**

Despite well-warranted concerns about incentives for managed care organizations to skimp on care, there is little evidence to suggest that care has deteriorated substantially. There is even reason to be hopeful that the play of competitive market forces will substantially benefit some groups of consumers. The Health Employers Data and Information Set (HEDIS) and other batteries of quality indicators have become common. Standardized measures of quality are used to compare quality of care in different settings, identify best practices, target clinical areas for quality improvement, and guide better purchasing decisions by large employers. Although tools such as HEDIS are currently crude, broad effort—supported by the government, private foundations, health plans and purchasers—is under way to improve them and make them more relevant to special populations, such as those enrolled in Medicaid and Medicare.

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*“Concerns about the large number of uninsured have lost their urgency, but the problem has not disappeared.”*

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Even with crude indicators, publication of standardized comparative data can spur quality improvement. One example, based at hospitals rather than health plans, is the New York state experience with publication of risk-adjusted mortality data for patients undergoing coronary artery bypass graft surgery. These sorts of data have been collected annually since 1989 on every cardiac surgeon and hospital in the state and released publicly since 1991. The statistics have been in such widely read newspapers as the *New York Times* and *Newsday*.

The publicity has had a considerable impact. Hospitals in the state have targeted coronary artery bypass graft surgery for quality improvement efforts and instituted technical improvements in the procedures. Physicians who performed this sort of surgery infrequently and had poor mortality statistics have been encouraged to discontinue practice. According to New York state statistics, mortality after coronary artery bypass surgery decreased by 21 percent and risk-adjusted mortality decreased by 41 percent during the four-year period between 1989 and 1992. Although mortality statistics after bypass surgery also improved nationally during this period, the changes in New York state were significantly greater.

Competitive markets have also stimulated a host of quality improvement efforts in health plans through-

out the country. Employer groups are applying continuous quality management techniques and negotiating with health care providers to demonstrate measurable improvement in quality of care. Innovators such as the Intermountain Health System in Utah have demonstrated that important improvements in quality can go hand-in-hand with reduced costs. Although skeptics will argue that advances to date have been more smoke than fire, the level of activity at health plans across the country is broad enough to suggest that market forces can promote higher quality as well as lower costs.

#### **Disadvantaged Populations**

Private health reform may result in greater value for large segments of the American population, but its impact on many disadvantaged persons is unclear. Two groups, those insured by Medicaid and those who are uninsured, are particularly vulnerable.

The success of the private sector in using managed care to control costs together with accelerating budgetary pressures have prompted many states to convert their Medicaid program from traditional fee-for-service coverage to managed care. The number of Medicaid beneficiaries enrolled in managed care increased from 2.5 million in 1991 to 13.3 million in 1996, according to the Office of Managed Care of the Health Care Financing Administration. This group comprises approximately 40 percent of the Medicaid population. The fastest growth has been in fully capitated health plans, which now provide care for approximately 70 percent of the Medicaid managed care market.

The use of capitation for Medicaid enrollees has been controversial. There are potentially strong advantages in converting Medicaid to managed care, however. Greater integration of services provided by managed care provides opportunity for improving the care of individuals with multiple chronic conditions. Use of managed care also provides an avenue



for specifying accountability and setting performance goals that was impracticable in the fee-for-service system.

Nevertheless, many worry. As with privately insured persons, health plans including the Medicaid population have a financial disincentive to provide all needed medical services. Most plans have little experience caring for disadvantaged populations, and many are unprepared to meet the characteristic challenges of this population: poor nutrition, illiteracy, and problems with transportation and communication. Medicaid beneficiaries may also have particular difficulty navigating the complex bureaucratic structures of managed care organizations.

The other group that seems threatened by the growth of managed care is the uninsured. In the last four years concerns about the large number of uninsured persons in the country have lost their political urgency, but the problem has certainly not disappeared. Between 1988 and 1994 four million fewer people were covered by employment-based health insurance. Although expansion in Medicaid partially compensated for the loss of employment-based coverage, the number of uninsured individuals has continued to grow. Today approximately 40 million Americans lack health insurance at any point in time; another 29 million individuals are underinsured for the consequences of serious illness they may suffer.

During the national health reform debate there was substantial controversy about whether the number of uninsured persons in our country constituted a crisis. Whether a crisis or not, there is appreciable evidence that uninsured persons are less likely to see health care providers in a timely manner, and are more likely to be hospitalized for conditions that could have been effectively treated by outpatient care. In addition, uninsured persons generally receive fewer medical services when they are seriously ill and have worse health outcomes.

The growth of Medicaid managed care ironically may both improve care for Medicaid enrollees while destabilizing the safety net that has anchored care for the uninsured. For many years inner city physicians, academic health centers, and neighborhood health centers have been the cornerstone of care for the Medicaid population and the uninsured. With the growth of Medicaid managed care, this network is being replaced by a new combination of providers that includes both commercial HMOs and health plans that serve predominantly Medicaid enrollees.

Many health plans participating in Medicaid managed care have incorporated traditional safety net providers. However, there are still fears that many neighborhood health centers, inner-city physicians, and municipal hospitals that have traditionally served the Medicaid population may be unwilling to join managed care organizations or unable to meet their credentialing requirements. Reduction in Medicaid revenues for these providers coupled with market pressures and price competition will make it increasingly difficult for these providers to provide the charity services that now underpin care for the indigent and uninsured.

#### **What Happens Next**

Although the failure of the Clinton administration to achieve comprehensive health reform may have seemed at the time like a national vote for the status quo, today it seems clear that federal failure to reform the health care system merely transferred much of the responsibility to the private sector and the states. Federal legislation and the regulations developed by the Health Care Financing Administration and other federal health care agencies will always be important. But increasingly the focus of health policy will lie in the purchasing decisions of large-scale employers, the marketing and managerial decisions of managed care organizations, and the administrative

rules and legislation passed in 50 different states.

The next few years will be critical, as private health reform is still very much a work-in-progress. Decisions made in the evolving medical marketplace will determine whether conversion to managed care leads to integrated medical services, better quality and more efficient care, and whether managed care disrupts the safety net that now anchors care for the Medicaid population and the uninsured.

Perhaps the biggest uncertainty involves the uninsured. Not only is their number likely to grow with current market forces, but there is little sign that the problems of their medical care are likely to resolve on their own. Federal and state legislation to reduce the number of uninsured incrementally seems likely. And, ironically, reductions in employer-based coverage will probably increase the proportion of middle-class uninsured, thus transforming the uninsured into a much more powerful political constituency.

The evolving balance between these forces and the concurrent changes in the health care delivery system will ultimately determine whether the problem of the uninsured continues to fester quietly or resurfaces as a major dilemma. In the past we have been able to improvise, relying on a threadbare safety net to provide adequate, if not optimal, care to the uninsured. In the future we may be prompted again into formulating a more deliberate national policy. ❧

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# Two Heads Are Better Than One

by Joshua Sharfstein

FOR MONTHS I READ OF MERGER mania in the health care industry with only passing interest. So what if hospitals, doctors and managed care plans were pairing up like animals in line for Noah's Ark?

As a medical student and occasional patient, I had plenty more to worry about than the latest billion dollar deal.

Until three months ago.

That's when I opened my mail to find a memo from my dean entitled "Merger of Boston Medical Schools."

"This merger is our last attempt to protect our share of an increasingly competitive market," the memo read. "It will require consolidation at all levels of administration, teaching and health care delivery. As a fourth-year medical student at Harvard, you will merge with a fourth-year student at Boston University. We have tried to merge students with similar interests and of similar heights, although this was not possible in all cases. Please call the registrar if you have any questions."

My hands trembled as I put down the notice, and my mind raced. Merge with another medical student? Was that humanly possible?

Then I laughed. The deans must have gotten together and hatched a prank. (But was that humanly possible?)

I ran to a phone and dialed. "Boston Medical Schools Registrar!" a woman answered cheerfully. "How may I help you?"

"About the merger," I asked. "Why?"

"Cheaper, bigger, stronger," she said.

"When?"

"Monday," she answered. "Thank you for calling."

I put down the phone in shock. Faced with an uncertain future, pushed and pulled by forces out of my control, I began to rationalize.

Hey, no more lonely nights on call alone in the hospital, I told myself. Twice the brainpower might lead to

higher scores on my standardized tests. Hey, would I only pay half the tuition bill?

Now I was starting to cheer up. Nothing like the prospect of lower prices to stifle opposition. I dialed the registrar back.

"Boston Medical Schools."

"Tuition?" I asked.

"The merger saves us money, not you," she said. "No different from any merger these days."


"Well, what if it doesn't?" I demanded, giving way to anger. "Or what if the merger turns out to be bad for doctors? Or patients?"

"If this merger is not good economics, everything will change again," she assured me. "But if it's not good for doctors, where else are they going to go? And if it's not good for patients, who'll ever know?"

I had no answer. "What if I promise to study twice as hard? Then do I have to merge?"

She responded stiffly. "If you don't understand how financial pressures are transforming the health care system, that'll be a great topic to discuss with yourself after you've merged. And please don't call again if it's just half of you."

That was three months ago. In the time since, I have followed news of mergers with a lot more interest. The reports generally focus on the executives, stock prices or the total number of "lives" covered by the mega-plan. But now I see that it's the little person—the patient, the medical student, the hospital worker—who has to live with the changes.

Being part of a merger has finally opened my eyes. All four of them. 

*Joshua Sharfstein '96 is a first-year pediatrics resident at Boston Medical Center and Children's Hospital. This first appeared in the Boston Globe on October 21, 1996.*





photo manipulation by Brian Bollinger



# Competition Among Friends

by *Ellen Barlow*

IT WAS AN ANNOUNCEMENT THAT caused a “tectonic lurch” felt by all of medical Boston, reported one local newspaper. When Massachusetts General and Brigham and Women’s hospitals announced at the end of 1993 that they were forming an alliance, shock waves were felt well beyond Boston. For if these Harvard titans felt the economic imperative to form an alliance, then who could afford not to act? Locally it portended a rearrangement of the Harvard medical landscape that has carved up the major teaching hospitals into two, possibly three separate health care systems.

Though it remains to be seen if bigger is indeed better, the major Harvard teaching hospitals are now set on competitive courses, vying for the largest share of the patient market. Once one group got together, the others had to do something or get left in the dust. And now, as that dust is settling in the Longwood medical area, the major teams have been formed: Partners HealthCare System, the parent company of MGH, BWH and the North Shore Hospital; CareGroup, the parent of the merged Beth Israel Deaconess Medical Center, Mt. Auburn Hospital, and four hospitals of the Deaconess’s former Pathway Network; and Children’s Hospital, which is remaining independent while still talking with the other systems and amassing its own pediatric services system.

Nor are these the only changes among Boston’s teaching hospitals. In July 1996 Boston University Medical Center merged with Boston City Hospital, ending a 132-year tradition of direct municipal health care for the poor, although the hybrid Boston Medical Center will receive city subsidies to provide accessible health care. Then in December 1996, a collective sigh of relief could almost be heard

among the Boston medical community when Tufts-New England Medical Center, after much shopping around, finally chose Lifespan—a nonprofit chain based in Providence, Rhode Island, affiliated with Brown University—over Columbia/UCA Healthcare Corp., a for-profit chain, which has been prowling for a Boston tertiary care facility.

**The first alliance: Mass. General and Brigham and Women’s.**

photo composites by Stuart Darsch





Massachusetts has one of the highest percentages of its population enrolled in HMOs—43 percent, or of those insured, 60 percent—so managed care is the most often cited instigator of revolutionary change here. With more and more payments being capitated and price-competitive contracts being struck, costs have had to be contained. Lengths of stay have dropped, beds have been empty, and as more treatment has been shifting to outpatient settings, hospitals have been left with excess and expensive technical capacity. Those that had built heavily were caught short of repayment capital. And just as federal grant money for research was getting scarcer, teaching hospitals with research missions, which traditionally have used clinical monies to fill in the research granting gaps, were facing their own shortfalls.

Dean Daniel C. Tosteson '48 was aware that these forces were producing irrevocable change and in January

1993 convened representatives (the CEO, the chairman of the board and a key physician) from each of the five major teaching hospitals (MGH, BWH, BI, Deaconess and Children's) to discuss the future of Harvard medicine and how they might all work together. Six months into the discussions, the MGH and BWH decided to talk on their own, leaving some hard feelings in their wake.

The story of what has happened would be different if told by faculty physicians, different if we were to speculate how Massachusetts patients might fare as a result. But this is the story of where six of the Harvard teaching hospitals are going and how they got there, through the eyes of their chief executives, the ones who say they are taking these new risks because the risk of not doing anything could mean the demise of their historical missions.

### Choosing Partners

Partners was not the first hospital consolidation in Massachusetts, but it was the kingpin of the teaching hospitals. In fact the partnership was forged in part to take a leadership role in reorganizing health care delivery. It represented two hospitals coming together not because they were financially desperate but rather from a position of relative strength.

The two hospitals—despite being cross town from one another and having very different medical “cultures”—agreed to affiliate to achieve economies of scale and to increase their share of the patient-care market by creating what they call a “physician-driven integrated health care delivery system.” The centerpiece of the Partners system is a network of 750 primary care physicians (the goal is to have 1,000 by 2001), who are the ones making decisions about care and where in the network continuum their patients should be at any given time: in tertiary, community, or rehabilitation hospitals; in nursing homes; or at home with home health care.

Partners  
System



"We saw ourselves as two vigorous hospitals, with excellent medical staffs, each attracting excellent house staffs, and each either number one or number two in the nation among independent hospitals in attracting federal grant money," recalls H. Richard Nesson, MD, president of Partners and BWH. His counterpart in negotiating the alliance deal was J. Robert Buchanan, MD, then general director of MGH, who retired soon after the arrangement was forged. "Dr. Buchanan and I knew each other well and had vaguely talked about doing something together before, an unheard of thing." But in the final analysis, the question for them came down to: why compete and erode each other further, when we could collaborate?

The intention was never to integrate both hospitals into one building or fully merge in the legal sense, which would have meant merging their names into something new. They both wanted to keep their institution's own names, "our best brand names." After all, MGH, founded in 1811, is the oldest hospital in New England. There are some things you shouldn't tinker with.

The Brigham is a newer entity— itself representing a merger in 1976 of the Peter Bent Brigham, the Robert Breck Brigham, the Free Hospital for Women and Boston Lying-In. Nesson, who had just started at the Peter Bent Brigham, oversaw those changes, and attributes the confidence he had to sit down at the table and negotiate with MGH to that experience, knowing that something could be worked out.

From Nesson's point of view, the meetings of the five teaching hospitals that the dean was sponsoring were not getting anywhere. "It failed with a large group of people to move forward toward substantial rearrangement despite all kinds of meetings." He and Buchanan decided to continue talking on their own and so informed the dean. Four people from the Brigham (including Eugene Braunwald) and

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*As the dust is settling in the Longwood medical area, the major teams have been formed.*

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four people from the General (including Gerald Austen '55), plus legal experts, worked together on the deal and then scheduled a retreat on December 8, 1993. "Even I didn't know before the retreat that the group would decide to take a meaningful step and not a half-step at getting together," says Nesson. When the retreat was over, the news broke.

On the Friday before the retreat Samuel Thier, MD, then president of Brandeis, accepted the job as CEO of the MGH. He was first the president and then, in July 1996, chief executive officer of Partners.

When asked by a reporter one year later what it was like to take the helm of these hospitals at such a pivotal point, Thier responded, "It's one of the only jobs I can imagine that makes a university presidency look like playing in a sandbox." Thier had "cut his teeth" at Mass. General, from intern to staff member, so he was seen as one of the family. But he had also been on the staffs of Penn, Yale and Hopkins, and had been president of the Institute of Medicine of the National Academy of Sciences, so he also had the "sense that other places were capable of carrying out the academic mission." He came here "convinced that what Dick and Bob and the trustees had done made sense. The MGH would be in trouble if it didn't adjust."

The MGH staff were in shock and wondered why they needed to do this.

"If you sat down with people, intellectually they knew this was the right thing and had been done thoughtfully, but emotionally they wondered if we really needed someone else's help," says Thier. "Despite all the anxiety, when they calm down, they realize they are joined with an equal."

So what exactly has resulted from this affiliation? In addition to creating a network of primary care physicians called Partners HealthCare, Inc., they have:

- achieved a savings of \$150 million toward a goal of \$325 million over the next several years.
- consolidated and centralized administrative departments, including finance, treasury management, human resources, community benefits, real estate and planning, information systems and telecommunications, biomedical engineering, materials management, and general counsel.
- consolidated or cut back residencies and fellowships 20 percent; of the 19 common residencies, 8 are fully integrated.
- reduced the number of beds 20 percent (though recently volume has increased).
- signed on a third partner, North Shore Medical Center, in September 1995.
- centralized some service laboratories, with radiology next.

Partners is bringing adult oncology under one umbrella with Dana-Farber Cancer Institute, and they are slowly consolidating other clinical departments as opportunities arise. Since the two chiefs of orthopedics are retiring, they are now seeking a single chief to head both. "Neurology spontaneously came together," said Thier, and next to be combined is psychiatry. Added Nesson: "We're trying to do this with the least disruption possible."

Thier notes that it is important to remember that these two hospitals did not in fact have much overlap in the patient populations and the areas they served. They were criticized for not taking consolidation seriously when



right after the affiliation agreement was announced, MGH revealed that it was opening an obstetrics service. "BWH deliveries were down from 9,000 to 8,000 per year and our survey showed an overlap population between the two hospitals of only 5 percent," says Thier. A MGH obstetrics unit would draw new patients, they figured, people who wouldn't have crossed town to the Brigham and would otherwise have been lost from their system. "This was a whole new region to open up," says Thier. "In fact, this year the combined deliveries will be more than 10,500—a 25-30 percent increase. Consolidation and integration of services cannot be made too simplistic."

A month before Thier was to accept the MGH job in 1993, he was asked to speak on the fate of academic medicine at the annual meeting of the Association of American Medical Colleges. Rather than looking at the future as something fated, he chose Chekhov's play "The Cherry Orchard" as a framework for discussion. In the play a family must decide whether to keep or sell their cherry orchard to save their home, but due to indecision, their orchard is chopped down and they lose their home. Asked to comment how this reference applies now, Thier chuckles and says, "Well, we avoided chopping down the cherry orchard."

### **Formation of CareGroup**

Clearly the direction MGH and BWH took left the other teaching hospitals in a quandary. No one institution alone could offer the breadth and depth of Partners. One can imagine the amount of time that has been spent the past few years at other hospitals behind closed doors with consultants, legal advisors and suitors of every sort.

At the Beth Israel Hospital, Mitchell T. Rabkin '55 had to consider what to do. "The joining of the Brigham and the General created a massive institution that in many respects overshadowed the BI. Although we certainly ranked right up

there in terms of clinical care and maybe ahead in terms of warmth and personalization of care, the intellectual enterprise was by no means comparable."

The Deaconess felt similarly and being even smaller, felt it even more acutely. The BI and Deaconess had specialties that were complementary, and they were geographic neighbors. "It looked like joining together we could really round out and develop a merged institution of reasonable breadth and depth," explains Rabkin. "Together we could basically pony up to the bar at Harvard Medical School and not be the 97-pound weakling that everybody kicks sand onto."

After months of planning, the hospitals announced their formal merger in October 1996, forming the Beth Israel Deaconess Medical Center. Mount Auburn Hospital was also part of the merger, and including the four hospitals that had been part of the Deaconess's Pathway Network—N.E. Baptist, the Deaconess-Nashoba, the Deaconess-Glover and the Deaconess-Waltham—there are now six hospitals under the parent corporation called CareGroup. They celebrated the merger on the medical school's Quadrangle, with congratulatory comments from Dean Tosteson and Senator Edward M. Kennedy, among others.

It appeared to take an impressively short time to merge the identities of the BI and Deaconess. New signs on Brookline Avenue went up right away. Phones were answered in offices throughout both hospitals: Beth Israel Deaconess. Medical staff quoted in newspapers were attributed correctly. The logos of the two were imaginatively coalesced to form one. This is all the frosting, of course, and the rest of the hard work of merging is under way.

"We have to take this system of ours and try to develop it into one that encompasses a large geographic area, with community hospitals and doctors in the community, and work it essen-

tially to the advantage of these local doctors and local hospitals," says Rabkin. He points out that there has been a revolutionary realization on the part of teaching hospitals, which have always been focused on the acute episode of care: doors swing open in the emergency unit, a complicated case comes in, you save a life. Teaching hospitals still have to be concerned with technical excellence and care for the most complex and problematic of cases, he says, but the real issue now in health care is health of the population.

"This means that instead of being intensely concerned with whatever patient happens to cross our moat and get into this medieval enclave, where they get the very best, we have to be concerned with the countryside," says Rabkin. "That means not that we want all of the countryside to come here, but rather another revolutionary concept for teaching hospitals: most care, most prevention, and most promotion of health belong in the community, where people are, and not at the teaching hospital."

One might ask why the BI and Deaconess chose to merge legally and not just affiliate. "I think if you're really going to make it work, the closer you are, the better it will work," says J. Richard Gaintner, MD, former CEO of Deaconess and Pathway Network, then president of CareGroup. "Legally, financially, programmatically, and managerially it's better. This is one of the things we and others have learned from experiences across the country." A merger also made sense to them because the BI and Deaconess are right across the street from each other. "The more we can consolidate as one total organization, with single financials and incentives aligned, (and the only way to do that is to be completely part of one another), the more successful you will be in controlling costs and gaining market share."

Gaintner believes the new game is not just cutting costs, though you have to be efficient. "I really think the game is more on the revenue side by grow-



ing your market share, which you can't do in a managed care environment as a single institution. But you gain market share by driving your prices as low as you possibly can. It's a price game."

Even though Gaintner was already leading a network, he knew he had to forge other arrangements. "Someone said that bigger is better. Well I don't know if it's better, but if you're not bigger, you're not going to be around to find out. It's a very tough environ-

ment. Boston has sustained lots of academic institutions for a long time, but there's only so many academic programs you can support."

When he came to Boston from Albany Medical Center in the summer of 1989 to head the Deaconess, he found an excellent hospital, but one that was very focused on adult medical and surgical care for people with diabetes, heart disease, cancer and AIDS. They didn't do obstetrics, didn't do

pediatrics, did very little gynecology and had a level-one emergency service, so they couldn't take care of really serious problems. "We did a lot of soul searching and realized that the way the world was going, we were not going to be able to survive on our own." Gaintner was already open to forging relations in the Longwood medical area with the other hospitals who did what the Deaconess didn't do.

When the dean convened the





## Beth Israel Deaconess Medical Center

foray into acquiring or hooking up with other hospitals.

Six months later, when MGH and BWH decided to splinter off for discussions on their own, the BI, Deaconess and Children's continued to talk, but neither the BI nor Children's felt the time was right. Other community hospitals approached the Deaconess and by the summer of 1994, they had four hospitals under their new parent corporation, Pathway Health Network. Still looking for a strong teaching hospital to round out Pathway's services, Gaintner began discussions with New England Medical Center, but negotiations fell apart seven months later. Soon after, Rabkin called him and suggested they should talk again. "I said, hallelujah, I've been waiting for this!" says Gaintner. Mt. Auburn was also conferring with the BI, and by June 1996 the three were talking together.

There has, of course, been staff nervousness as a result of this merger. Communication is key, says Rabkin. A rumor swept through the Deaconess, for example, that because they were joining with the Beth Israel, they were not going to be able to celebrate Christmas anymore. "This is of course ridiculous," says Rabkin, "but when change is cataclysmic like this, people are whistling in the dark and rumors abound. The first two letters of merger are me—what is going to happen to *me*?"

They have tried to appreciate that social change in an institution takes place over a period of years. It may take four to five years to "reweave the fabric of the two institutions into one." And it means that "you have to communicate constantly and honestly with people, listen to what they're saying, and acknowledge them as part of the process," says Rabkin.

The Beth Israel Deaconess is planning a physical rearrangement: one board of trustees, one management, one department of medicine. Although the two hospitals are now connected by the "world's longest open-air corridor," they want to work out something

better so that residents on one campus can easily get to the other to see a patient in the middle of the night. (The BI is now the "east campus" and the Deaconess is the "west campus.") They are in the midst of proximity studies: if the emergency unit is on the west campus, what clinical services should be proximate to it and what could be at the other campus? You need cardiology, trauma care, the helicopter pad nearby, for example, but not obstetrics. What are the costs—functionally and financially—if the location of a unit is on one campus versus the other? "This is the kind of thinking that goes into proximity studies," says Rabkin, "and we're doing it department by department."

CareGroup's network of physicians, physician groups, hospitals and nonacute facilities is not fully formed, and they are "trying to work out ways to grow the system in strategic ways." They want the system to be fully integrated so patients can move seamlessly from one office or institution to another, based on what physicians determine is best for them in terms of level of care and cost issues, and get patients back close to home as soon as appropriate.

What it will come down to is "a balancing act," says Gaintner, "I call it the mission/money dilemma. How do you do what you need and want to do and still survive from a financial standpoint?" With a small percentage of the population generating most of the cost, the only way it will work is if you have a broad base of insurance, so that people who don't have problems essentially cover those who do. But the problem is that "the only way to make money in managed care is to enroll as many people as possible who don't have problems and exclude those who do," says Gaintner. "They deny this and around here it is not a big issue. But there's this old story that in California an HMO put their enrollment center on the third floor without an elevator: if you were healthy enough to walk up there, they wanted

group of teaching hospitals in 1993, "I was a great advocate of trying to get all of the Harvard Longwood institutions together," says Gaintner. "That was my fantasy. I have great respect for MGH, but they're across town and a different venue. Under that scenario the Deaconess would have fared very well." Right around this same time, Nashoba Hospital in Ayer came to him, asking to be under the Deaconess umbrella, and that became their first



**Children's Hospital stays independent.**

you; if you couldn't, they didn't."

Gaintner has just been lured away to the University of Florida to be CEO of Shands Health System, an organized delivery system involving the University of Florida in Gainesville. But he emphasizes that he really believes in the CareGroup construct. "When I came to Boston in 1989, the Deaconess had 489 beds and the BI had 504. We're planning to run a 650-bed hospital and my guess it could go down to 500 beds. That's half what we both had. Like it or not, that's part of the game."

#### **Children's Strategy**

Children's Hospital has been wooed by many of the health care systems, but has remained steadfastly determined not to tie itself exclusively to one system. "We honestly believe that when you have a unique resource like Boston Children's it should be made accessible to everybody," asserts David S. Weiner, CEO of Children's. "Ideally what I'd like to see us do is develop an independent pediatric delivery system, with Children's at the core, that responds to the needs of multiple systems."

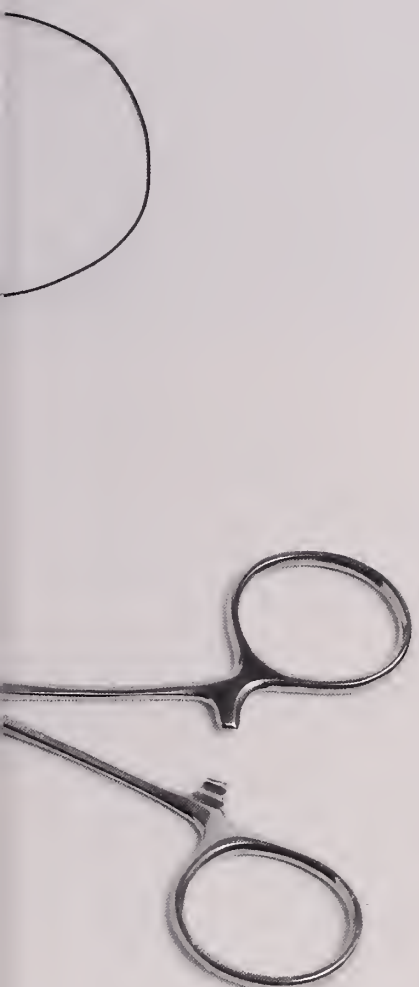
This strategy is consistent with the hospital's mission to provide care to all children who need top-quality care

and their families, says Weiner, and "we believe it is also politically sensible to have no exclusives, because to the extent you make it to the competitive advantage of one system, you're cutting yourself off from another."

This attempt at independence—or at being Switzerland, as one observer affectionately termed it—"doesn't mean we don't need to develop affiliations with other adult systems," Weiner emphasizes.

Their overall institutional strategy is to create a "high quality cost-effective system of pediatric care throughout the Boston area through setting up our own sponsored satellites, and by connecting with pediatricians in the





since 1988. This brings specialized pediatric services to the community and “affirms our commitment to seeing that any child who needs care is locally based as much as possible.” It also serves to redeploy staff.

Children’s also operates a 71-bed pediatric long-term care facility in Groton and last year purchased Night Train Pediatrics, an after-hours triage service for parents of sick children. Piece by piece they are adding to their system.

Times have changed, and the future objective is not necessarily to fill beds here in Boston anymore, points out Weiner, though “when a patient does need complicated secondary or tertiary care, we’d like to think that there are enough screening and protocols at the local level to determine when a child should be referred here.”

The payback is the increased leverage a system such as this may have in negotiating and contracting with insurers. As the *Boston Business Journal* pointed out last year when Children’s announced its plans: “The contracting advantages alone could be enormous, if only because many HMOs may be loathe to exclude such a popular hospital from most people’s insurance coverage.” In fact, Children’s has negotiated contracts with all of the region’s major payors.

Children’s Hospital is 127 years old, the second oldest children’s hospital in the country (after Philadelphia’s), and one of only about 25 to 30 academic pediatric centers. It trains more pediatric specialists than any other center in the world; last year its pediatric training program, newly consolidated with Boston City Hospital’s, was the most sought after in the country. Boston’s Children’s is the top pediatric facility in receipt of federal research grant monies.

But that very success puts an extra financial pinch on Children’s. “We’re nervous that just about every payor today is looking to avoid costs unrelated to their objectives and that means costs of graduate medical education,

research and community service, which are three key pieces of our mission,” says Weiner. “That’s why we’re aggressively advocating at the state and federal level for an all-payor pool for graduate medical education.”

Children’s is also hurt because “the bulk of payment to hospitals comes from Medicare and independent children’s hospitals are Medicaid-focused.”

Weiner acknowledges that there are economic risks to the strategy they have devised. Just as there is excess capacity among Boston’s teaching hospitals, there are excess pediatric services. Not all can or should survive. And though Children’s is fully prepared to rationalize services, Weiner says, they fully expect to be one of the survivors.

#### **Collaborating on Cancer**

David Nathan ’55 says he took on the presidency of the Dana-Farber Cancer Institute a year and a half ago knowing that he’d be making changes in the way adult clinical oncology was practiced there. The institution was ripe for change, in part because of the publicized chemotherapy overdoses. From his pediatric experience at DFCI and at Children’s—he had been chief of pediatric hematology/oncology for both before becoming Children’s physician-in-chief—he already had a model.

“We have the Jimmy Fund Clinic at DFCI which is just a nonpareil, magnificent program for children with cancer and there’s no clinic like it anywhere in New England,” he explains. “But when children get sick, either from their treatment or the disease, there’s no place like Children’s Hospital for inpatient care, so all our patients go there. I wanted to reproduce that for adults.”

Hospitals have the “bells and whistles” necessary to take care of acutely ill patients who require hospitalization. “But cancer centers, I think, are much better in ambulatory care and about 85 percent of care of a cancer patient is ambulatory.”

communities and with community hospitals.” They also plan to expand their base of national and international referrals.

Children’s already has three outpatient satellite clinics—in Chelsea, Lexington (with the Beth Israel Deaconess) and Peabody—and is building a network of “relationships” with pediatric primary care physicians. They plan to forge model affiliations with community hospitals, as they recently did with Winchester Hospital. Children’s pediatricians will provide inpatient and urgent pediatric care coverage for Winchester 24 hours a day, and will continue to staff the Special Care Nursery as they have

Because there was already a bridge to the Brigham, says Nathan, that was the logical place to go. The fact that the Brigham and the MGH had formed Partners opened an opportunity to integrate adult oncology care across an even larger system. "Among the three institutions there are about 200 oncology beds and almost 200,000 visits," says Nathan. "We asked ourselves how we could put this all together into a fascinating and new approach to cancer care that would allow us to become one of the largest providers in the country and have seamless quality and excellence, whether you got into the system from the MGH, Brigham or the Farber."

Their collaborative program, Dana-Farber/Partners CancerCare, was announced in January 1996. Not a merger, but rather a "joint venture," it involves adult care only. DFCI has moved its licensed beds to the Brigham and the Brigham's ambulatory oncology program will be moved to the Dana-Farber; the MGH will maintain both its outpatient and inpatient programs. Oncology patients will have access to care at any one of the three institutions, researchers will have a larger pool of patients with rare cancers, specialists will consult throughout the system, and clinical guidelines will ensure care is consistent and current.

Thus far all cancer care between the Brigham and DFCI has been integrated. "It is hard to imagine how complicated this was," says Nathan. "It required moving patient beds, closing clinical laboratories here and opening there, integrating information systems. There was one issue after another to resolve."

The next step is to integrate cancer care between DFCI/Brigham and the MGH, an even larger undertaking because the volume of adult cancer care at MGH is equal to the combined volume of DFCI and the Brigham. "Plus they have their own way of doing things. Their system of care is more private-practice oriented and

ours is more of a clinic-based team approach. But if we're going to advertise that we have a common system, we're going to have to compromise."

Nathan says that this is not an exclusive agreement with Partners in that they will continue established arrangements with the BI—for example, an advanced breast cancer treatment program and head and neck program. "But obviously the Beth Israel Deaconess Medical Center will have its own cancer program so the vast predominance of what we do will be with Children's and Partners." They will still care for other patients, in part because the DFCI is a federally designated regional cancer center, and is federally mandated to care for anyone who needs help.

DFCI is building what he terms a patient- and family-oriented system that will offer unsurpassed cancer care. He says the DFCI is also far better off financially by getting rid of its inpatient beds: "You can't break even with 30 or 40 beds." Nathan says the DFCI receives enormous public support, but that's because of "public confidence that we'll find a new approach to cancer, not that we'll fund a deficit on a small number of beds. Unless of course the small number of beds is better for patients, which it's not."

One of Nathan's top concerns is "the constant slashing of reimbursement that has cut down the ability of hospitals to support research." Nathan, who heads an NIH committee investigating the effects of shrinking revenue to support promising clinical scientists, says that doctors are feeling beleaguered and, from anecdotal evidence, are afraid of getting into science careers.

"Basically we've always relied on the teaching hospitals to have enough money in the till to support young physicians," says Nathan. "We can't do that anymore. There's this latest cheery idea that we're going to cut Medicare more. Well, here we already lose \$2 million on Medicare patients; that's just one teaching hospital losing



\$2 million. We do more for patients than insurance will reimburse us for. Where are we supposed to get the money?"

The crisis is serious, he believes. Chemistry and physics funding is declining rapidly, and these are two disciplines upon which biomedical research depends. "We may not notice it right away but in a decade there will be a lot of information we won't have. As a country we are dropping into second tier with respect to the fraction of GNP that goes into research and development. It won't take long before we're feeling second tier."

### **Competitive Forces**

Though clinically these six Harvard teaching hospitals may not be "all for one and one for all," they all say they are expressly concerned with their research and teaching mission. Inevitably there has been some erosion of collegiality because to compete means to accentuate the differences. But as David Weiner of Children's says, "I fail to see why competition needs to preempt rational collaboration and integration of effort among Harvard and its teaching hospitals."

In discussing competition, several





Dana-Farber/Partners  
CancerCare.



CEOs pointed out that competition can improve things for everybody, including patients. Sam Thier of Partners quotes Harold Shapiro, the president of Princeton, who said that at a certain level competition can be seen as cooperation with ground rules. "We want to make sure our competitors are the strongest we can have," says Thier.

With two strong general hospital systems, there is naturally competition, but as Mitch Rabkin of CareGroup says, it is not competition to destroy the other so much as "I want to be the best so I'm going to do the best we can." He believes there are still many collegial things happening and that the hospitals are finding other ways of sharing.

But how have the realignments affected Harvard Medical School? Because patient care is interwoven so closely with medical research and education, comments Dean Tosteson, the accommodations to change that the Harvard-affiliated hospitals have made "have had a great impact" on Harvard medical faculty who work at these institutions. "To the extent that the

new arrangements between the hospitals are a sincere effort to improve the quality, cost-effectiveness and accessibility of health care and sustain and strengthen the academic mission of education and research, I applaud," says Tosteson, who points out that it was concern about the need for such restructuring that prompted him to convene the leaders of the five largest teaching hospitals four years ago.

"However, the current situation falls seriously short of my hopes. Many members of our clinical faculty are caught in a painful bind between their obligation to participate in the increasingly ruthless competition with their colleagues at other institutions for clinical business and their desire to collaborate in research and education. Competition between Harvard-affiliated organizations saps energy and focus on competing with other private and public providers of health care outside the system. It also distracts attention from the important problem of access to health care for the poor and underinsured."

Tosteson's hope now, he says, is

that "additional mergers or partnerships between Harvard-affiliated healthcare institutions and Harvard faculty physician organizations will move in the direction of a more coherent, cooperative, collegial and, therefore, productive Harvard medical community."

"A lot of the tension that was in the system has already dissipated," points out Richard Kitz, HMS faculty dean for clinical affairs and for 25 years chairman of anesthesiology at MGH. "It's easier to get people in the same room because they're feeling more comfortable and less threatened. The firmament of Harvard medicine is clearer now." But the concern remains that with "all this attention to the business of medicine that research and education are not forgotten."

Kitz already had his eyes on retirement when he was invited by the dean in October 1994 to, as he says, "work the issues between the school and its affiliates." "There are 18 affiliates!" Kitz said he responded. "Is this one of those mission impossible assignments that will self-destruct if I don't

## The Other Twelve

**The other Harvard-affiliated hospitals have their own strategies for economic survival.**

**Massachusetts Eye and Ear Infirmary is still independent and part of its strategy is to stay independent. Though the hospital has long-standing programs and relationships with Brigham and Women's and Massachusetts General hospitals, MEEI would like to continue to see patients from all plans and systems of care.**

**Joslin Diabetes Center, for the past ten years, has followed a growth strategy of establishing affiliates (essentially franchises) around the country.**

**These affiliates (now numbering 14) sign an agreement and pay an annual fee, and in exchange can use the Joslin name, receive procedures and protocols for the Joslin-style diabetes practice, and have site visits and network conferences. Joslin also has five local diabetes center satellites. As for arrangements with other hospital networks, communications director Julie Rafferty says: "At this point Joslin has affiliations with hospitals in the Boston area and is talking about how these affiliations can be broadened."**

**The Cambridge Hospital merged last July 1996 with Somerville Hospital, creating the Cambridge Public Health Commission. This is the governing board for the two hospitals, the health centers that were previously connected with the two hospitals, the Cambridge Department of Public Health, the Neville Manor Nursing Home, and the Cambridge Hospital Professional Services Corporation (their practice plan). Cambridge Hospital is also in the process of talking with both Partners and CareGroup, "hoping to establish a tripartid arrangement so we can affiliate with both," according to Luke Wennik, assistant manager of public**

**relations. "We consider this absolutely essential for survival."**

**Massachusetts Mental Health Center is still a state-run facility, which continues collaborative relationships with HMS and other mental health facilities in the Boston area. MMHC has not merged with anyone, says Ming Tsuang, MD, PhD—superintendent of MMHC and HMS Stanley Cobb Professor of Psychiatry—who adds "Mass. Mental's mission is unwavering."**

**Harvard Medical School has a total of 18 affiliates. The others are: the Spaulding Rehabilitation Hospital and McLean Hospital, both of which**



accept?" "No," the dean said, "this one won't go away."

In essence, for the past couple of years Kitz has been working to help ensure that the divisiveness among the teaching hospitals does not impede the academic discourse that transcends the faculty's institutions. In Kitz's estimation the faculty are HMS. "I think the purposes of a university are, as John Henry Cardinal Newman at Oxford said so marvelously, 'to store knowledge, to disseminate knowledge and discover new knowledge'. Now who is responsible for this? It's the faculty who do the research and teaching, not those of us in administration."

As Kitz further points out, there are 14,000 appointees (including residents and fellows) and more than 90 percent of them are in the affiliated hospitals. No one could be more committed to the medical school than the leaders of that faculty, he says, the ones with appointing privileges and who allocate the resources to other faculty to do the research and teaching. "They are the glue that holds Harvard faculty together," says Kitz. Using himself as

an example, he adds that as chief of anesthesiology, "I was as truly committed to the affairs of the medical school as I was to MGH; I'd bleed crimson as well as blue."

He meets regularly with faculty leaders of the 16 clinical departments, under the aegis of Harvard, where they discuss promotions, appointments, residency programs, research that cross cuts institutions, such as center grants and program projects, and communications from the dean. His office oversees compliance with the "Guidelines for Faculty Compensation" and "Guidelines for Practice Plans."

And recently, he and colleagues at Countway Library and the HMS Department of Information Technology have created a virtual Harvard Medical Center using World Wide Web technology. Called the Harvard Medical Center Network, it provides computer links to all of the affiliates and clinical departments, pre-clinical departments and student societies. Its purpose is to support the inter-institutional mission of research and teaching, to "break down some of the impediments there are to moving around the system and allow our faculty, students and residents to communicate throughout," says Kitz.

But getting back to the crux of the matter for HMS: how can the school be certain the teaching and research mission will be preserved and enhanced when the faculty are mostly "out there" and "out there" has changed so much? First CareGroup, then Partners, made major commitments by appointing senior physicians as vice presidents for academic programs, Michael Rosenblatt '73 for CareGroup and Eugene Braunwald for Partners. Both are faculty deans for academic programs at the medical school, and thus hold high-level appointments at their hospital systems and the medical school. Starting last fall, they began to meet monthly together as the dean's Council of Academic Deans with colleagues holding similar appointments: Thomas Inui, MD at Harvard Pilgrim

Health Care, Philip Pizzo, MD at Children's, and David Nathan '55 at the Dana-Farber.

As Dean Tosteson steps down at the end of June, one of the challenges for his successor, Joseph Martin, MD, PhD, will be to catalyze further unification on the research and teaching missions. Martin, who is currently chancellor of University of California/San Francisco, has said that he looks forward to taking on the challenges of returning to Harvard, where he was chairman of neurology at MGH from 1978 to 1989. As he has also said, this is an unstable time for academic medicine and Harvard is no exception.

*Ellen Barlow is editor of the Harvard Medical Alumni Bulletin.*

**are affiliated with MGH and Partners; the Judge Baker Guidance Center, part of Children's; the Brockton and West Roxbury V.A. Medical Centers; the Center for Blood Research; and the Schepens Eye Research Institute.**

**EB**



'60s

# Changes and projected changes in the relative sizes of five racial-ethnic groups in the U.S. population 1980-2050

- White
- Asian
- Hispanic
- Native American
- Black

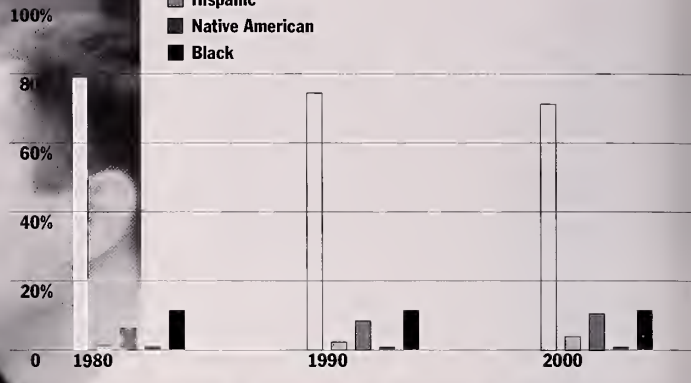


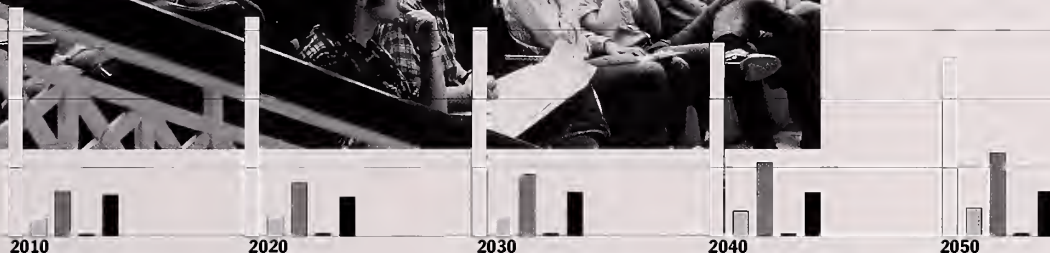
photo by Liza Green

'90s





'70s



# Complexion of Change

by Jordan J. Cohen

## *Finishing the bridge to diversity*

WE IN ACADEMIC MEDICINE ARE CHALLENGED as never before to build that metaphorical bridge to the future, which is so much the rage these days. We are working especially hard to find ways to sustain academic medicine's core missions as we bridge the turbulent sea of changes swirling around us.

Within our world, there is a long-standing challenge that needs our commitment: finishing the bridge to diversity. This bridge-building challenge differs a lot, I think, from others that are commanding so much of our attention. For one thing, although the tools we need for this work stem, as always, from carefully honed analyses of the data, those tools must be sharpened for this particular task by something in addition to data—by deeply felt passion.

To establish the context for my remarks, let me review some familiar facts. The population of the United

States continues to grow and will do so well into the next century. The truly dramatic change to come, however, is not the size of our population but its composition. Our population is growing older, as everyone knows, and it also is growing racially and ethnically more diverse. Minority populations are increasing much more rapidly in this country than is the majority white population. By the middle of the next century, the majority of our citizens will be members of minority groups.

*What do these striking demographic trends describing the future complexion of America have to do with our responsibilities as stewards of medicine's future?*

Academic medicine is, after all, about improving the health of future generations by educating the physicians who will care for tomorrow's children and by discovering better ways to keep tomorrow's children healthy. Given that our primary obligation to society is to furnish it with a physician workforce appropriate to its needs, our mandate is to select and prepare students for the profession who, in the

aggregate, bear a reasonable resemblance to the racial, ethnic and gender profiles of the people they will serve. In other words, a medical profession that looks like America.

*Why should anyone care if the medical profession reflects society's racial and ethnic makeup as long as we have plenty of well-trained practitioners of whatever background?* The reasons are many, but five stand out in my mind:

First is the simple matter of justice and equity. The medical profession, and the health professions in general, occupy a lofty status in American society, and offer those who pursue them many of the most challenging and rewarding career opportunities available anywhere. For us to seek justice within our own profession is, I believe, only to be faithful to our cardinal commitment to respect everyone's individuality equally.

The second reason is a matter of improved access to health care for the underserved. Abundant data now exist to document unequivocally that black, Hispanic, and Native American physi-

cians are much more likely than whites and Asians to practice in underserved communities. Not that minority physicians are, or should be, under any obligation to do so; not that minority physicians are not, and should not be, free to settle and practice wherever and however they chose; and not that other physicians do not contribute importantly to improving access among the underserved. The simple fact is that minority physicians do so with greater predictability. Getting the job done means producing more minority physicians to lead the way.

The third reason for increasing diversity among our students—and faculty, I might add—has to do with learning how to deliver culturally competent care. Given the expanding diversity throughout our society, all physicians of the future will need this essential skill, and must be given a strong foundation in what it means to deliver culturally competent care. If they are truly to care for their diverse patients, physicians of any background must have a firm grasp

## Enriched by Diversity

The most striking change over the more than 25 years that I have been involved with the HMS Admissions Committee has been the increasing diversity of our student body in terms of gender, ethnicity and background. Our process is truly gender blind and half of our students are now women. We also have a responsibility to train physicians for our increasingly pluralistic society, and that means including students of all races and ethnic backgrounds. We are all enriched by the diversity of our students.

The phrase "affirmative action" has been used to describe some of these efforts and with it come misconceptions: that there are quotas or that poorly qualified students are being offered places. Nothing could be further from the truth.

All students we accept demonstrate outstanding scholarship and intellectual curiosity. Most are science majors, but many are not. We value breadth of education as well as the ability to pursue something in depth, whether it be scientific research or an honors thesis in the humanities.

But we look for more. One of our committee members said, "Being smart is not enough.

You have to be nice." Personal qualities are just as important as academic accomplishment. We look for qualities of leadership, integrity and a commitment to serve. Our students bring with them an impressive list of talents, out-of-classroom activities, life experiences and community service. Many have had to overcome personal hardships and have emerged stronger for these experiences. We are seeing an increase in the number of somewhat older, nontraditional applicants who bring with them a set of experiences and a level of maturity that adds leavening to a class.

Our programs put a premium on good communication skills and the ability to work together. Good communication

skills also mean good listening skills as well as the ability to communicate easily with people from different nationalities and ethnic groups.

We look for these qualities in the applications submitted, in letters of recommendation and in the personal statements written by the applicants. These are read by members of the Admissions Committee and those with the most compelling credentials are invited for interviews (about 20 to 25 percent of close to 4,000 applicants last year).

Although hard to validate, the interview plays an important role. It gives us a sense of whether someone is not just smart, but nice. We learn



on how various belief systems, cultural biases, family structures, historical realities, and a host of other culturally determined factors influence the way people experience illness and how they respond to advice and treatment. Such differences translate into real differences in the outcomes of care.

A fourth reason for addressing diversity has to do with our research agenda. Our society as a whole is plagued by unsolved health problems, many of which revolve disproportionately around our minority populations. Our country's research agenda is set in large measure by those who have chosen careers in investigation. Individual investigators, in turn, tend to do research on problems that they "see" and are of interest to them. And what people see depends to a great extent on their particular cultural and ethnic filters.

My final reason for achieving diversity in the medical profession relates to management of the health care system. Physicians must continue to lead in the management of the health care enterprise, especially now that that enter-

prise is becoming increasingly corporatized. But assuming management responsibility for a system destined to serve the health care needs of an increasingly diverse people is a job that can only be done well by equally diverse management teams. We must draw the future physician leadership for our health care systems—as we must for all other professional and nonprofessional sectors of the American economy—from a richly diverse pool of talent, adequately reflecting our country's gender, racial and ethnic *mélange*.

Let's take a historical look to see how are we doing in our quest for diversity. Until the mid 1960s the racial and gender composition of medical school classes was composed primarily of white men. Despite a progressively expanding, double-digit presence in our population, groups that we now designate as under-represented minorities made up only about 2 percent of medical school matriculants, and three-quarters of those attended either Howard or Meharry.

The typical medical school of that

era admitted one minority student every other year. I graduated from Harvard Medical School in 1960, one of the off years. In my class of 140, there were 134 white men and 6 white women. And that was a banner year for women. In my 1965 residency class, there were no women, no blacks, no Hispanics, no Native Americans, nor any Asian Americans. Racial segregation was as fully evident in medicine as it was in virtually every sector of American society, just as it had been for many preceding decades.

But things began to change in the late 1960s, and academic medicine was among the first to get the wake-up call. The result was a dramatic rise in the admission of minorities to medical schools. Was this because Scholastic Aptitude Test scores, grade-point averages, and Medical College Admission Test scores of minority students suddenly began to skyrocket? Of course not. What changed was simply that academic medicine began to take affirmative actions to increase the racial, ethnic and gender diversity of medical school classes.

Enrollment of under-represented minorities in U.S. medical schools rose rapidly to about 8 percent of all matriculants by the early 1970s. However, progress on diversity stalled in the mid seventies, with admissions remaining virtually flat for the next 15 years or so. To make matters worse, the fraction of individuals from the same groups in the U.S. population that were under-represented in medicine continued to grow during this period, increasing from 16 percent in 1975 to 19 percent in 1990. Our bridge to diversity, in other words, was less than halfway across the chasm and the gap was widening before our eyes. Clearly it was time to call in the engineers to reevaluate our bridge-building strategy. We did so, and the result was the AAMC's Project 3000 by 2000.

The architects of this project recognized that the root cause of minority under-representation in medical schools in this era is the accumulated

**something about communication skills and personality. Applicants have an opportunity to tell us more about themselves and we have an opportunity to explore accomplishments and values. Applicants also have an opportunity to learn more about us. Medical schools interview. Law schools do not. Perhaps there is a message there.**

**So that's our student body and the qualities we look for. The selection process is a collaborative effort of more than 50 faculty and 20 students in any given year. About 20 alumni in Atlanta, Chicago and California participate in our regional interviewing trips to these areas. It is not exactly a science, but it is a careful and**

**fair process. For the members of the Admissions Committee, it is a time consuming and intensely rewarding experience. The end result is a student body of which we can all be proud.**

***Gerald S. Foster '51 is HMS faculty associate dean for admissions.***

academic disadvantages of too many minority young people, simply because they lack access to high-quality, pre-college and college educations. Thus, the project aims, over the long term, to effect small-scale educational reform. Science education partnerships have been created to identify promising students early in the educational pipeline, enrich the science and related offerings available to students from poorly equipped schools, establish mentoring relationships to keep the flames of inquiry and aspiration burning intensely, and to provide adequate counseling to ensure that all the milestones on the long road to medical school are understood and met.

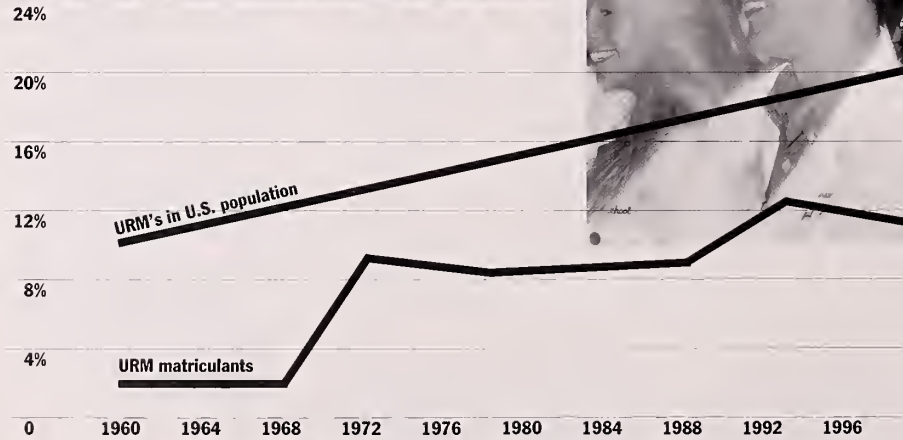
After the launch of Project 3000 by 2000 we saw a second dramatic upturn in the number of under-represented minorities admitted to medical school. But over the last two years, progress has lapsed once again. One reason for the project's early success was the new

attention it focused on the lack of adequate racial and ethnic diversity among medical students. We saw a significant increase in the fraction of under-represented minority applicants who gained acceptance at virtually every school. The measurable progress made during this initial phase validated, once again, the power of affirmative action as a short-term remedy.

Now it's precisely such short-term remedies that are in jeopardy. What may be running out of steam is our commitment to affirmative action programs, programs designed to reach out not only to those qualified young people from under-represented minority groups who are already in the applicant pool, but also to those who should be in the pool, and to those who, through short-term academic enrichment efforts, could qualify to enter the pool. The suspicion that weakened affirmative action efforts may be the culprit here has an obvious reason,

given the way affirmative action is being attacked on so many fronts. Critics of affirmative action raise repeatedly the question whether the use of affirmative action as a tool, and the resulting increase in the number of minority medical students, leads to unqualified individuals becoming doctors. To raise such a question is to concede ignorance of the facts. No one would argue for admitting anyone to medical school who did not evidence the academic skills and personal qualities necessary for completing the MD degree. Such an admission policy would not only violate our oath to patients, it would be a disastrous disservice to individual students. The vast majority of medical students from under-represented minority groups, as is true of all students admitted to medical school, do successfully complete the rigorous requirements for graduation. Medical school admission committees cannot

# '60s



# '90s

**Admission of under-represented minorities to medical school**



be commended enough for the care they take in selecting our country's future physicians. That only a handful of students from all backgrounds, majority and minority alike, prove unable to withstand the rigors—or meet the financial costs—of a medical education and must abandon the quest along the line, is ample testimony to the skill and wisdom of our admission committees.

Those who oppose affirmative action, and I know many of you do, argue either that it's no longer needed, or that it's ineffective, or that it's unfair. Looking at this contentious issue from the vantage point of the medical profession, I maintain that all three of those arguments are false.

*Is affirmative action in medical school admission still needed?* Absolutely. Until the academic credentials of all groups in the applicant pool are indistinguishable, we simply cannot use the same criteria to evaluate all applicants. Given the disparity in available measures of academic achievement among applicants grouped by race and ethnicity, there is simply no way we can select an adequately diverse class of medical students today without taking race and ethnicity explicitly or implicitly into account. We must continue for as long as necessary to reach out to those whose race and ethnicity, not their economic status alone, have subjected them to inferior academic preparations, but who, by dint of character, intelligence and drive are fully prepared to succeed as physicians and medical scientists.

*Is affirmative action ineffective?* Certainly not in medicine. Indeed, nowhere is the effectiveness of affirmative action more in evidence than in our profession. Effective not only in narrowing our diversity gap, but effective in greatly expanding access to care.

*Is affirmative action unfair?* How can it be unfair to boost the chances of becoming a physician—to give special treatment to persons who have been subjected to unfair discrimination because of their heritage, and whose status in our democratic society remains tarnished through no fault of their own? What about fairness to other applicants who don't get the benefits of affirmative action? Most applicants to medical school come away empty-handed, and do so for a whole variety of reasons. To single out affirmative action for their disappointment and plead unfair treatment just doesn't compute.

If one of my kids or grandkids were rejected from medical school, I'd be damned disappointed. But if they tried to blame it on reverse discrimination, I'd say: get a life. Because I believe it's time already to share the wealth, to recognize that our profession needs—and our country needs—the best talent it can find from every group in our society.

As much as we'd like to think otherwise, and as much as we long for the day when it's no longer true, race and ethnicity still matter in America. To ignore that reality in deciding who deserves to be admitted to medical school is to ignore our duty as stewards of our profession's future.

We must continue to produce physicians and scientists from all segments of America. We must remember how many young minority physicians, with their many talents and abundant energy, would have been lost to us if the enrollment practices from my era in medical school had not been reversed by affirmative action. But simply repeating the rhetoric of the 1960s will not be enough. We must face up to the fact that our society is being hammered at present by a mean-spirited backlash.

All of us must speak out. This is a moral issue, and it is a health issue. Hence, it is our issue. And the data are compelling. The consequence of abandoning affirmative action programs

prematurely will be a reduction in the availability, and a deterioration in the quality of, health care services for everyone.

We must finish the bridge to diversity we began to build in the 1960s. We cannot allow thoughtless attacks on affirmative action to dismantle the fledgling structure we have yet to complete, a structure without which at least some of our minority colleagues would never have attained their dreams, never have healed a patient, never have discovered new knowledge, never have led an institution, never have inspired a student, and never have graced our profession. ❧

*Jordan J. Coben '60 is president of the Association of American Medical Colleges. This is adapted from his address at the annual meeting in San Francisco on November 8, 1996, and was published in its entirety in the February 1997 issue of Academic Medicine.*



photos by Thomas Corlin



photo by Marc Baroni





# Taking It to the Streets

by Janet Walzer

EVERY STREET CORNER IS DIFFERENT. Here at the corner of Columbia and Washington in Dorchester, Robert sits inside the Family Van as his 16-year-old wife, Lisa, has her blood pressure checked by nutritionist Ellyn Baltz. Robert's family history of high blood pressure and diabetes prompted his first visit to the Family Van just a week ago. Robert, who is 20 years old and works at a nearby restaurant, is studying for his high school equivalency, and notes that his career plans had to change "once there was a baby on the way." Robert and Lisa are now the parents of two-month-old Anna.

After spending about 15 minutes on the van, Robert and Lisa leave—Lisa with a healthy blood pressure of 98/58 and some nutritional information for Anna, and Robert with a stack of flyers about the Family Van written in English and Spanish. Robert has offered to distribute the flyers because "A lot of people need treatment and they don't know it's around."

The Family Van has been "around" the most underserved areas of Boston for five years, first hitting the streets in January 1992. The idea originated three years earlier when Nancy Oriol '79, HMS assistant professor of anesthesia and director of obstetric anesthesia at what is now called Beth Israel Deaconess Medical Center, heard a National Public Radio piece on infant mortality. Oriol, who is founder and executive director of the Family Van, hoped that a mobile unit that tailored

its services to meet the needs of a neighborhood could make a difference. With the help of Cheryl Dorsey '92, Edward Lowenstein, HMS professor of anesthesia, and Mitchell T. Rabkin '55, the current CEO of CareGroup, the Family Van became an idea realized.

Although infant mortality was the impetus for the van, Oriol says the mission was always broad. "Infant mortality is only a symbol. We knew that the specific needs of our community would be redefined over time. It's logical to check blood pressures, do pregnancy testing, offer certification for Women Infants and Children Supplemental Food Program (WIC), and help people understand the bureaucratic maze of health care. But in terms of health education and resources, we had no preconceived notion since every street corner is different. People and times change and issues change."

What has not changed in the past five years is that the Family Van serves as a bridge, referring clients to community health centers, service agencies, and the multiple resources in their neighborhoods. There are over 100 local programs to which van staff can refer clients. The type of resources that might be needed, according to Oriol, "depends on who crosses the bridge. Our job is not to diagnose or treat, but to open a door."

It is Oriol's dynamic spirit and down-to-earth approach, shared by

that of the van staff, that explains much of its success. The van now covers seven Boston neighborhoods, and the Family Van National Initiative has been established, with the first Family Van outside of Boston opening last November in Providence, Rhode Island.

The van itself is a 35-foot long Winnebago with "We are Family" emblazoned in turquoise on its sides. Inside it is easy to forget it is a motor vehicle. The walls of the van are covered with information on reproductive health care, healthy cooking, heating fuel assistance, food pantries and job assistance. Stations are set up for blood pressure checks and individual counseling, and there are bins full of supplies, clothes and toys.

From 9:00 am to 12:00 pm, and again from 1:30 pm to 4:30 pm Monday through Thursday, the Family Van parks at the same location in seven different neighborhoods, regardless of weather and traffic. This consistency is not overlooked by clients, notes national director Tamara Callahan '95, who remembers one client saying, "The van comes to us. It kept coming and I finally came in."

Mobility is one of the van's greatest strengths. It reaches clients who often are not seen in neighborhood health centers or clinics and attempts to address the specific needs of each community. Boston director Claire Craig says the van's place in the community is unique for additional reasons. "We

offer a comfortable, no-questions-asked environment for clients to get support and information on health and life issues. Most staff live in the same neighborhoods our clients do. We provide access to medical care and to people who care.”

This idea of accessibility is echoed by project coordinator Aleisa Gittens-Carle. “The climate is changing and people are trying to find out what’s available to them. People often don’t feel comfortable or confident asking about services. A person comes in for a blood pressure check, but there are other issues happening. You have to have a keen sense of hearing.”

This ability to hear the other issues is a trait that all van staff and volunteers appear to share. Although many clients who come on the van this particular morning request a blood pressure check, they have other things on their minds. Every person who steps out of the van is armed with information. One young woman new to the city leaves with a potential job inter-

view and tips on losing weight; another client leaves with emergency formula and WIC certification for her three-month-old daughter; another now knows her blood glucose level; and several others have referrals for further care.

Some clients come in to discuss their health problems with people who make the time to listen. James is a case in point. Although his blood pressure is a normal 120/80, he complains of heart fluttering, “losing his step,” dizziness and thirst, and he has a family history of diabetes. Whereas many of the clients who visit the van do not have a regular health provider, James has a primary care doctor at a health center just a few blocks away. As he describes his symptoms Craig takes notes, and after more questions learns that James sees a psychiatrist, whom he does not like. Craig asks for James’s primary care doctor’s name who will be given this information before James’s next appointment. James came in looking disoriented and nervous,

but as he steps out of the van he looks relieved and says thank you several times.

Although James came onto the van on his own, van staff also rely on community outreach workers like Natacha Alexandre to attract clients. Alexandre has been working with the van for about a year. She serves as a representative of the health center on the van and also as a representative of the van in the neighborhood by doing outreach.

“It’s an excellent program because it’s preventive and saves lives,” says Alexandre. “People become familiar with the van. They like that it’s confidential and private.” Alexandre’s skill becomes apparent as the van fills to standing room capacity. When she runs out of flyers Alexandre returns to the van and smiles, “I sent you a lot of smokers, didn’t I?”

Project coordinator Gittens-Carle, who has been on the van the longest, has seen the program grow “by leaps and bounds” since beginning her work

## A Respected Option

**HMS students have always volunteered their time and skills to a variety of causes and services in the community. Now an effort is under way to acknowledge these students with academic credit and financial support, just as the school does with student participation in research and international work.**

**As often happens, energy by both HMS faculty and students toward a goal coalesces simultaneously. While Nancy Oriol’s work with the Family Van established her as a public service contact for both faculty and students, a group of stu-**

**dents were inspired to draft a proposal to formalize their work in the field. After a highly successful presentation to the Faculty Council, Dean Tosteson asked that a subcommittee be formed to review the specifics of the proposal, which resulted in the subcommittee on public service, with Oriol and Gerald Fischbach named co-chairs.**

**Since then the Faculty Council has given its support to an honorarium to all students who perform significant community service, and to the development of a community service day, similar in scope to Soma Weiss Day. It is now being determined how academic credit can be given.**

**Audrey Bernfield, director of the Office for Enrichment Programs, is coordinating these efforts in conjunction with Oriol, Judy Bigby ’78 and Roxanna Lerner Quinn of the Holmes Society. “Our office has always tried to work with other student groups, but now we’re saying to students that HMS values this and also recognizes student debt and the need for a stipend,” says Bernfield. “Labs offer stipends, as do international efforts, so why not here? We have to acknowledge the costs of doing community service.”**

**Oriol points out that although 90 percent of incoming HMS students have done some type of community service, this number drops to 60 percent**

**once students are in medical school, often because this work is not supported. Oriol, who has been honored with an award from the Massachusetts Medical Society for her work in the field, observes that “Medical students today are more community minded than the previous generation. Public service needs to be seen for its impact on science. It’s not just about doing good. It’s relevant.”**

**This acknowledgment is beginning to come in different ways, including financial support. A mailing to all faculty chairs from Dean Tosteson, Oriol and Fischbach has generated \$36,000, and another mailing is in the works. These funds will provide a stipend to each**



in August 1992. In the beginning Gittens-Carle was the only staff person on the van, aside from Oriol and Dorsey and the driver. The once small staff has now grown to team size and on the van this morning in addition to Gittens-Carle and Baltz, are HSPH student volunteer Proochista Ariana, smoking cessation counselor Priscilla Elliot, and driver Joaquin Alicea. As Gittens-Carle talks it becomes clear why she continues to do the work. "I like my job. It's the perfect atmosphere to work in, with different people and different agencies. You get a sense that you're really doing something."

The numbers certainly confirm that the Family Van is doing something with over 18,000 client visits since opening day. About 60 percent of clients are reproductive age, with an equal number of men and women visiting the van. Many of the clients are returnees who often bring their friends. In 1996 there were over 700 family planning visits and more than 800 visits from teenagers. The number

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## *Most staff live in the same neighborhoods as their clients.*

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of elderly clients is increasing and staff note that many of these senior citizens are taking care of their grandchildren and/or neighborhood children. Often after these clients get their blood pressures checked they ask for diapers and formula. "Whatever it takes to make a strong family," comments Callahan.

Indeed van staff want to reach everyone in a family, as WIC nutritionist Baltz notes. "I see everybody, not just pregnant parents, but also teenagers and grandparents." Baltz finds her work satisfying because she has had the opportunity to create both an affordable and nutritionally sound program for van clients. After review-

ing some statistics she began to suggest the "Five a Day" nutrition plan which promotes fruit and vegetables and addresses such health problems as heart disease, diabetes and asthma that are seen regularly in clients. Yet Baltz is sobered by all the work that still needs to be done. She makes an increasing number of referrals to food pantries and says some free meals are no longer totally free. "Even if a free meal costs a dollar or two, that still might be too much for a family."

The van's success is bittersweet since it indicates that the need exists and shows no signs of letting up. "If our clients no longer needed the van, that would be the greatest day ever," says Oriol. Oriol worries that as other issues vie for public attention funding might become difficult. "Having identified a need and a solution, it is our responsibility to support this success. So far we have been fortunate in finding dedicated funders, but it takes a lot of effort."

The Family Van is unusual in that

student and will cover the costs of Dean Ebert Day, the community service day named for the late Robert Ebert who devoted much of his time to the community. This year's Dean Ebert Day will be on May 29, 1997 and students will present posters and receive certificates and honoraria.

As with research and international programs, Bernfield says one of the goals is to establish a centralized clearinghouse for HMS students to access information on agencies and programs. A formal resource book is to be compiled, and already there are listings of community service openings in *Expanding Horizons*, the newsletter put out by the Office of Enrichment Programs.

Some community service work has been formalized. One such program is the Big Brother/Big Sister program at the Judge Baker Guidance Center. Fifteen HMS students spend one-on-one time with students one afternoon a week. Students also have contact with the teachers, psychiatrists and social workers of their little brothers/sisters, which broadens their experience. The Urban Health Project, a student-run program that was created by HMS students, offers many opportunities for student participation in the community. In addition, there is now a community service representative on the student council.

"We're trying to develop programs that will continue after the student goes to the wards," says Bernfield. In the past when students worked out in the community there was no continuity after the students left to do their clinical rotations. Bernfield and her colleagues also want to encourage the development of diverse programs. For example, a student came to see Bernfield about creating a manual on Asian languages, since medical students are seeing an increasing Asian population in the wards. Already in place is a program where students take an intensive one-month course in Spanish before heading into the community to work with Hispanic and Latino populations.

Bernfield recently woke up in the middle of the night thinking about how to make all this come together. "First we had to raise the money. Now it's time to get all the students together and hear from faculty who are working out in the community and want to involve students. We're excited and the students are eager."

*JW*

with the exception of WIC funding it does not rely on any government assistance. Over one-third of its \$400,000 budget continues to come from Beth Israel Deaconess Medical Center and the Beth Israel Deaconess Anesthesia Foundation, which supplies all the overhead for the van, office expenses and drivers' salaries. Support also comes from over 50 private groups, corporate sponsors and smaller foundations.

In the last few years there have been many calls requesting information on establishing the program outside of Boston. The foundation that subsidized Dorsey's position and now Callahan's—echoing green—has taken the lead in supporting the Boston site as a national model. The goal, however, is not to create exact duplicates of the Boston Family Van in every city. "The mission is to help other cities and towns design their own Family Van programs that will meet the needs of their specific communities," explains Callahan.

Among Callahan's responsibilities is to identify people who can build and run their own Family Van programs outside of Boston. The initial idea was to stay close to home, which is why Providence was chosen. Working primarily from a \$125,000 grant from the H.E.L.P. Coalition (Health and Education Leadership in Providence), staff at Women and Infants Hospital and Brown University started the Family Van in Providence. Callahan shuttles back and forth between Boston and Providence providing technical assistance and moral support and will do the same for the next city.

"We're in the community every day, as well as in the institutional arena. With several Family Vans, each can learn from the other, do larger projects and also attract larger funders," says Callahan. Aside from serving new communities and establishing a network, Callahan believes the national initiative will eventually impact health care policy. In this vein, the Children's Health Fund, estab-

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*"Students come away with respect for the individual and how that person's reaction to health care fits into their world."*

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—Nancy Oriol

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lished by musician Paul Simon and pediatrician Irwin Redlener in New York, serves as a model.

Since van staff hear first-hand what issues prevent clients from accessing services, they are in a unique position to facilitate how local health centers can best provide for community residents. For example, van staff noted that a group of elderly clients returned week after week for glucose monitoring at one particular site. The local health center had not been able to reach this elderly population very well, and with the help of the van, is now developing a program to address their needs.

Client needs are never far from the minds of van staff and volunteers. Clients for whom English is a second language are helped by staff and/or volunteers who are bilingual. But this emphasis on client care is not without stress. Gittens-Carle remembers that in the early days, without a formal support system in place, it was difficult to manage some of the feelings that were evoked after talking with clients. "People come in and unburden themselves and the staff is left with what the clients have said to us."

Now Beth Israel Deaconess Medical Center provides social workers to meet with staff when needed, and Gittens-Carle and her colleagues, among them project coordinator Rainelle Walker, debrief themselves

and use e-mail to get questions answered. Gittens-Carle says now the only down side to her job is not always knowing what becomes of the clients after they visit the van. Efforts are under way, however, to develop a tracking system.

This system is just one of the many projects in the works, according to Boston director Craig. Craig succeeds Ramona Hamblin, who had taken the reins from Dorsey. Expanding services to Chelsea, Hyde Park and Jamaica Plain is a possibility due to the number of requests from these neighborhoods. The van is seen as part of a continuum, says Craig, "an entry point for people into Boston's health and social service resources. We're working to improve coordination of outreach workers and other community groups, and planning to establish a community advisory board." Attention will also be directed to augmenting the nutrition program, including targeting specific cultural groups who may be at risk for diabetes and hypertension. And although still in the preliminary stages, Craig has been collaborating with the March of Dimes to coordinate a preconception and prenatal education program. Add a potential computerized database to serve as a central clearinghouse for social services, and that still does not cover all the goals Craig outlines.

In addition, collaborations with the medical community will continue, including those with HMS and Boston University students and physicians. Physician involvement from the Harvard community has been significant, with doctors volunteering to do staff tasks, and some issue-related services (eye exams, diabetes counseling). Craig says these collaborations happen both formally and informally. "Doctors have been incredibly responsive. I put out an e-mail and always get a response."

Some pediatric residents from Children's Hospital gave a workshop on child development, while others provided physicals and health education for youth in association with a



special event at the Suffolk County Probate Court. Other collaborations, such as Beth Israel Deaconess residents giving pre-camp physicals to “at risk” youth, occur the way much business is transacted in the busy world of Longwood. “I saw the pre-camp physicals as a means to address the lack of safe sex practices that occurs in this client group,” remembers Oriol. “I bumped into the chief of medicine in the hall and asked him about having his residents do camp physicals, while the Family Van staff did family planning and safe sex counseling. It was a great success.”

“Harvard provides a lot of human power,” says Callahan, noting there have been many students throughout the Harvard system who have offered their time and skills to the van.

Trevena Moore, MPH and current Harvard Medical student doing a fifth year, spent this past year putting her public health knowledge into practice, or as she describes it, “Taking the classroom to the streets.” Moore wanted to apply the principles of public health research to an emerging community-based program. In addition, she wanted to hone her medical knowledge by helping establish medical protocols for van workers. “I have seen first-hand how people’s issues go way beyond what we as physicians can offer by means of technology and health education. We also need extensive knowledge of the other types of services that exist in our clients’ communities.”

Marian Aiken ’95 is another HMS student who wanted to take a fifth year and “do something different.” She had always been interested in public health, and after talking with Oriol and spending a day on the van, she chose to devote two days a week to van-related work for a year.

Dubbed a “research fellow,” Aiken was given free rein to work on a variety of projects, including collecting data on the van’s catchment areas, developing educational materials and creating a database. “I wasn’t sure

what area I wanted to go into after medical school and my work with the van helped me decide on primary care,” says Aiken. She describes her time on the van as a “family kind of experience,” which was difficult to leave behind. Yet it has had a long-term influence on her career: “I want to do projects as a doctor that will impact the community.”

The value of this work for medical students is multi-layered, says Oriol. “Students come away with respect for the individual and how that person’s reaction to health care fits into their world.” Students also gain a better understanding of the context of people’s lives. “The working poor don’t have insurance. Doctors only see this group at an urgent point and wonder why. These clients have a great deal of pride. They don’t have money or time to fill prescriptions. It becomes a real learning experience.” Indeed, it is hoped that these learning experiences become formalized so academic credit and financial stipends can be received, making it as much of a respected extracurricular option as research and international work.

As Marian Aiken found, spending time on the van can also offer medical students a reminder of how fulfilling it can be to give back to the community. “You can’t do it all,” says Boston director Craig, who has worked in the human service field for close to 30 years. “But if you help one person every day, you’ve made a difference. We see people on the van whose lives we’ve changed.” ❧

*Janet Walzer is associate editor of the Harvard Medical Alumni Bulletin.*



photo by Liza Green

Harvey J. Makadon

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*“Who would have guessed that in the next 16 years this illness would change not only how medicine is practiced and drugs are researched, but also would provoke great social change.”*

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# Legacy of AIDS

by Harvey J. Makadon

IT WAS 1981. I HAD JUST STARTED working in a faculty primary care practice at what was then called Beth Israel Hospital when we began receiving disturbing reports of strange illnesses occurring mostly in gay men. At first it was gastrointestinal infections and too much hepatitis. Then there were cases of pneumocystis pneumonia (PCP) and Kaposi's sarcoma (KS). One night at a faculty meeting a colleague described a patient as having gay-related immune deficiency syndrome, soon to be called AIDS. Who would have guessed that in the next 16 years this illness would change not only how medicine is practiced and drugs are researched, but also would provoke great social change.

Soon the syndromes associated with AIDS were also reported in IV drug-users, hemophiliacs and eventually in others. Fear was widespread; many doctors refused to care for those with AIDS. Two of my primary care colleagues, Booker Bush and Kay Petersen, however, were the first to truly confront the disease in our practice and initiate what was to become a national model of primary care-based services for people with AIDS. At first I was not as eager. It was less fear of contagion than fear of the unknown, and also fear of being identified as what I was and am: a gay physician working in a world where at that time I could not imagine acceptance.

Yet a great deal was to change in the next decade. Much of this grew paradoxically from the epidemic or "the plague" that was affecting this community. In *When AIDS Ends: Notes on the Twilight of an Epidemic*, Andrew Sullivan writes: "AIDS and its onslaught

imposed a form of social integration that may never have taken place otherwise. Forced to choose between complete abandonment of the gay subculture and an awkward first encounter, America, for the most part, chose the latter. A small step, perhaps, but an enormous catalyst in the renegotiation of the gay-straight social contract."

The gay community was not merely the passive recipient of this first step toward understanding; the community itself underwent enormous change. Individuals took responsibility for friends who became family, and advocated for services, using a model of self-empowerment adapted in part from the women's health movement of an earlier decade. It became clear that public health and politics were closely intertwined. For many of us it forced recognition that we needed to stand openly and proudly alongside friends who were ill, if one were to live an honest life and feel any sense of self worth. So the world adjusted. At times it was not easy, but in the long run, AIDS saved many a spirit, possibly mine, as it continued to kill the hopes, dreams and bodies of far too many others.

My first patient with AIDS was a 24-year-old man from Puerto Rico. When I first saw him his disease was advanced. He remained hopeful despite the fact that he had already experienced several bouts of PCP and was in the hospital being treated for cryptococcal meningitis. His parents, a thousand miles away, did not understand. He had two caring sisters and a loving partner who looked after him to the end. Fortunately, all agreed on

how his care should be handled when he could no longer make decisions for himself. After he died, he did return home.

AIDS has forced physicians, nurses and other clinicians, as well as hospital administrators, to confront social, political and economic issues that had been side-stepped or ignored in the past. How they were dealt with varied greatly. A resident I worked with had a patient with HIV who had an orthopedic problem that required a procedure. The consulting orthopedic resident said the procedure was elective and he would not perform it. Could this be permitted?

Around the nation, answers varied. I was pleased that our hospital leadership made it clear that AIDS was no different from other illnesses and that all patients deserved one standard of care. Many other questions were raised and, particularly in the early years, there were no easy answers. While it took time, AIDS has clearly led us to take universal precautions seriously, even though earlier warnings about hepatitis B exposure had not been heeded by many. That is not to say that students still do not complain about a resident who chides them for taking the extra time that safety demands, but progress does not make perfect!

Many situations arose that had never been thought through before. In retrospect, we did not always get things right on the first try. Policies about admissions to ICUs are an example: many hospitals had clear guidelines that patients with PCP could not be admitted, even once, to an ICU. Other hospitals ruled that this could not be done for second cases, as no

one was known to recover. On what basis and with what data were these policies set? Was the prognosis of people with PCP different from those receiving aggressive treatments for incurable cancers who were treated routinely in ICUs? Would such rules have been made had those at risk for AIDS not come from marginalized groups (gay men, IV drug users, hemophiliacs, with a disproportionate number from poor urban communities) whose routes to care had not yet been embraced by the medical profession? While we might argue how to use ICU resources now based on resource limitations, would we make decisions that were not equitable?

It seems fortunate that within the first few years of the epidemic, those with AIDS (first the gay community and then many other groups and individuals) grew together and made the medical community think through its decisions, deliberately and often publicly in ways it had not previously been called upon to do. There were many areas where this was and continues to be true: design of clinical trials to include not just white men but women, drug users, children, African-Americans and Latinos; legal designation of lovers and friends as health care proxies when traditionally recognized family members were not the trusted parties; availability of new medications for individuals who did not qualify under the definitions of clinical trials, but who had no other alternative to save their lives; the right to work and live a life without the daily threat of discrimination based on having AIDS.

The focus for clinicians during the first years of the epidemic was on treating those who were ill, while for researchers in the lab, it was trying to understand the nature of the problem and its transmission. When it was finally determined in 1984 that HIV (HTLV-3 as it was then known) was the cause of AIDS, it was announced with great fanfare. Margaret Heckler, then secretary of the Department of Health and Human Services, promised that

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vaccine trials would be under way within two years. But the dawn of the era of AIDS treatment came slowly. An initial report on the efficacy of trimethoprim/sulfamethoxazole (TMP/SMX), a mainstay in treating PCP, was initially largely ignored. Instead, attention was focused on the use of aerosolized pentamidine—an expensive, much marketed treatment which has now been demonstrated to be inferior to and far more expensive than TMP/SMX.

Even after the test to detect HIV was first created in 1985, there was little to be done medically before opportunistic infections developed. It was not until 1987 that trial results showed that people with AIDS or those with considerable HIV-related symptoms (then called AIDS-related complex or ARC) could benefit from an old drug—azidothymidine or AZT (now called zidovudine or ZDV). A study of effective treatment in those who were asymptomatic had yet to show promise. Finally, an NIH study called ACTG 019 (AIDS Clinical Trial Group 019) was discontinued in less than two years because data showed that people on AZT were less likely to develop AIDS or HIV-related symptoms. The study also showed that a lower dose was as effective, with less toxicity, though there was no evidence of increased longevity.

For a time things changed. Had hope finally eclipsed reality? However fragile the findings might seem in retrospect, we began to develop clinical

guidelines and ways to look at quality of practice. For the first time a consensus developed on how to treat patients with HIV. Some would say it was too pat and neat, but the first NIH guidelines for treating those with HIV were written in a manner to which the primary care provider could relate. The guidelines were a step-by-step approach analogous to how hypertension, not an unknown plague, was being treated. Although many patients were still skeptical, did not get tested, and felt AZT was poison, many did get tested and began participating either in new clinical trials or “standard” treatment—a recommendation to start AZT if T cells were under 500, and consideration for PCP prophylaxis if under 200.

Over the ensuing two to three years, less robust results were reported for AZT and we re-entered a time of uncertainty and ambiguity. Many participants in the Berlin AIDS Conference in 1993 came back hopeless and angry. Strategies had failed; there was not enough money; the epidemic was spreading with little evidence that prevention was working; the promised vaccine was nowhere in sight.

Practicing medicine was difficult. Patients who had already been on AZT and other available treatments hoped for a new treatment for HIV but had to do the best they could with prophylaxis against opportunistic infections. Sessions with patients who were having new symptoms were spent watching T cell counts fall—quiet, often tense, again surrounded by uncertainty, wondering about everything except the ultimate outcome. Was it different from cancer treatment? Probably not. Yet everyone was so young, so disfigured, with so little time left to achieve what could be.

I remember organizing an AIDS training session for physicians in Oregon and being in a small discussion group when one of the doctors said he felt he could not keep one image out of his mind: Whenever he sat with a new patient with HIV, he felt like there



was a video picture in his brain, watching a man run from life to wasting towards death. The only time I had this experience was during this time, when there was so little to do and so many in need.

I continued my practice, but also found myself turning my academic and educational interests to HIV prevention—a constructive way to channel both frustration and energy. Prevention had never truly been a significant part of medical education. It was only when I was a resident in the primary care program at Beth Israel that clinicians like Bill Taylor and Bob Lawrence '64 made it clear that prevention was important to learn and practice.

During meetings to evaluate how to involve physicians in HIV prevention, I was surprised that both public health officials and behavioral scientists reacted less than enthusiastically to the notion that clinicians should play a role in HIV prevention efforts. The idea was greeted with concerns about whether they should spend the time, whether it was worth their time, and to be honest, whether it was an appropriate role for physicians.

I asked about the impact of a physician's silence. What message does it give patients if their provider does not bring up the subject of HIV prevention? Is it analogous to not talking with someone at high risk for coronary disease about whether they smoke and helping them to stop? Physicians, in particular, can respond to questions in areas where data are ambiguous in ways that public health or social marketing slogans often cannot.

As Eric Rofes writes in his book *Reviving the Tribe*, "Marketing strategies often encourage men to consider sex acts as narrowly defined and circumscribed, requiring only simple discreet adjustments to be made safe, like an automobile with bad brakes. Yet erotic activity is complex and variegated, difficult to categorize and control, and filled with competing meanings." The physician visit offers

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## *Hope has gained ground; people are living longer.*

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the opportunity to engage in a more complex dialogue that can include, as Jonathan Silin and I describe in a paper, a "reciprocal search for mutual understanding in which culture and values are considered."

Now in 1997 the biggest question facing us is whether we have, in fact, to quote Andrew Sullivan again, "come to the twilight of the epidemic" and if so, whether and how this will ever be true globally. The introduction of protease inhibitors—expensive proteins that act at the end of the viral replication cycle, preventing the assembly and release of new HIV virions from CD4 cells—as routine treatment has revolutionized HIV care, but they are hard to produce. They have been shown, in combination with nucleoside analogues like AZT or d4T with 3TC, to have remarkable effects on immune function, and a two- to three-fold greater ability to decrease the amount of virus in blood than any previous treatment.

How true this is for all, how long-lasting the effect will be, and whether these drugs will be affordably produced so that they can be used outside the developed world and even by those within it, are major questions. It is clear they work and allow individuals who were wasted to regain both their spirit and their bodies. Hospices, like the heralded hospice on Mission Hill near the Harvard medical area, are closing for lack of patients. And the *San Francisco Bay Area Reporter* recently ran the headline, "Is it Time for the San Francisco AIDS Foundation to Downsize?"

These are indications that, at the very least, the epidemic is changing. Hope has gained ground; people are

living longer. Many on disability pensions who had cashed in their life insurance are wondering what they will do next. But despite headlines heralding the possible eradication of the virus, a "cure" is still not attainable. It seems that for many, at best, the virus will be contained. The question is, for how long? Many have already experienced the failure of protease drugs and are watching their viral loads climb. This is particularly true for those who have been on many medications in the past and have already developed varying levels of resistance. Will we again see an increase in the number of those succumbing to opportunistic infections, or will there be new protease inhibitors that are more powerful, with different resistance patterns to be used, possibly in combination with other therapeutic strategies that will boost the power of dysfunctional immune systems?

We face great questions at the end of the twentieth century. Will we make progress with new therapies fast enough to truly save those who are infected, and make them available for all who need them? We still must do what we can to keep new individuals from getting infected. But how will this be done when we cannot legally promote the most effective means to prevent the spread of HIV openly and honestly in our subways, on our television screens and in our schools. Finally, given the growth of the global epidemic, will we ever cure AIDS without eradicating AIDS globally? We have seen that developing nations have the will to engage in successful prevention efforts, but can it be done to the extent necessary, with the available resources?

AIDS has changed many of our lives. In fact, much about the way we do many things—from basic research and making new study drugs available to new drug approval and the way we work with our patients—have changed, in part, as a result of AIDS. People with AIDS have shown that they can and will work with the medical

community to make the entire medical industrial complex more responsive to the needs of those who have or are at risk for HIV. Early protests against governmental policies on AIDS research ultimately changed to a more responsible form of involvement by the community.

Reviewing the book, *Impure Science: AIDS, Activism and the Politics of Knowledge* in the *New York Times*, Jeffrey Goldberg writes: "It is not simply that AIDS activists began to understand the implications of double-blind, placebo-controlled tests that is so important; what matters most is that in reaction to the educated criticism of AIDS activists, government officials actually changed the way the science was done." In many ways, what is remarkable, he continues "is the revolution, sparked by AIDS, in the way diseases are studied and the practice of medicine is conducted...Lessons can be drawn—and are being drawn—by those who in the past were simply passive patients, relying almost entirely on medical experts to battle their illnesses as they saw fit: as the AIDS movement is showing, people with diseases (and those at risk for getting them) can play a profound part in saving themselves."

One must wonder if things would have been different had AIDS been a disease that affected mainstream America. Yet there has been great change. Now, if we can only incorporate into our practices what we have learned from AIDS, we will be in a better position to understand the needs of our patients and work together to champion changes in health care that will improve the health of the public, as well as the health of our profession and our own satisfaction in the century ahead. ❧

*Harvey J. Makadon is associate professor of medicine at HMS and vice president and medical director of Ambulatory Care and Community Health at Beth Israel Deaconess Medical Center.*

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# Medicine in Coal Country

*by Daniel Doyle*



AP Photo/Earl Nekirk

A coal company in  
Appalachia.

TWENTY YEARS AGO LAST SPRING, A group of West Virginia coalminers and their neighbors founded the New River Health Association and set out to build the New River Family Health Center. It was built right on top of old Wingrove Mine slate dump, along White Oak Creek. Lucky for me, I was there to help it happen, and to keep it happening ever since.

Access to health care—for themselves, their extended families and their community—that is what it was all about. Assuring and improving access to health care for one underserved Appalachian community is the soul of the New River Health Association (NRHA), Fayette County, West Virginia.

In the spring of 1970, Joe Gardella, HMS dean of students, conducted personal interviews with every member of the class of 1972. We knew his agenda: to query and counsel us about appropriate career plans. My friends and I fancied ourselves the nonconformists of the class. We approached this interview with both trepidation and truculence. We knew that Dr. Gardella wanted to know about residency plans and the development of a research interest.

The Vietnam War was raging. Kent State and its aftermath were only a few months away. Some of us were more preoccupied with the direction of American society than the direction of our careers. I was concerned and confused about both. What could I say to Dr. Gardella?

The day arrived. I walked into the office, closed the door, and sat down on the couch facing his desk. Each of us had the other's number.

"So Mr. Doyle, what sort of career plans do you have in mind after medical school?"

Compelled by irreverence and perversity, I blurted out, "I was thinking I'd be a family doctor in Appalachia."

"Well, if you are going to go there and do some meaningful research, it might be OK. But if you're just going to be putting band-aids on people, it

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## *The first few years were exhilarating and exhausting.*

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seems like an awful waste." Shortly thereafter the interview ended.

Eight years later, my wife, Linda Stein, and I enjoyed our first Appalachian spring. The redbud and dogwood lit up the steep West Virginia hillsides, followed a few weeks later by every shade of green. We had come to Fayette County to work with the NRHA, whose founders wanted to form a community health center so it would be easier for people to get in to see a doctor and not have to travel so far. They wanted better communication. They wanted things explained. They wanted preventive care, especially for women and children.

My wife was a health educator with a fine arts degree from Carnegie-Mellon, an MD from University of Massachusetts, and six years experience in mental retardation programs with the Massachusetts Department of Mental Health. Since my interview with Dr. Gardella, I had taken a two-year leave of absence from HMS to do community health work in Mission Hill and to put on band-aids as an orderly at Boston City ER. I graduated in 1974, did a rotating internship at Cambridge City, and completed a family practice residency at UMass in July 1977. We arrived in West Virginia that fall.

We had discovered West Virginia thanks to Craig Robinson, the son of a SUNY/Buffalo psychiatrist, who had come to West Virginia as a VISTA volunteer in 1967. He was organizing community clinics for the United Mineworkers of America when he recruited us in 1976. I then recruited him to be clinic administrator. We

persuaded the penniless NRHA board to appoint us as their initial management team, and Craig led us to the Rural Practice Project of the Robert Wood Johnson Foundation. The Rural Practice Project was trying to establish ten "model rural practices" around the U.S. based on a model of community responsive practice and physician-administrator leadership teams partnered with nonprofit community groups.

After successfully completing their initiation rites, including a detailed clinical and business plan for our fledgling practice, they awarded the NRHA \$412,000 to support clinic operations over the first three years. We opened our doors on June 8, 1978.

The first few years were exhilarating and exhausting. Local physicians were skeptical about a doctor who chose salaried practice instead of private practice. They were resentful of an organization that received federal and state funds to compete with them, even if it was nonprofit. Although most of the insured families of our community (including NRHA board members) preferred the Beckley Hospitals 20 miles away, I took care of patients in the nearby 80-bed Oak Hill Hospital. Along with two excellent PAs, we did general family practice, including prenatal care.

Our practice grew, gathering an interesting mix of indigent, Medicaid, Medicare, HMO, and insured patients, pretty much in that order. We were never a "free clinic," but we billed whatever insurance people had. If they had nothing, we saw them on a sliding scale that slid right down to zero. By the end of 1984 we had four doctors, two PAs, 30 employees, and a brand new facility. We were providing 20,000 visits to 6,700 users per year.

In the spring of 1984, Linda and I had our first son, Ben, and moved into a house we had just built. I took advantage of Ben's birth to resign as medical director of NRHA and pass the torch to a younger and very qualified colleague, Mike Herr, DO. By this time, NRHA



was providing more and more services that neither began with me nor relied on me. That is one of the greatest satisfactions of a community organizer: to see your organization reach the point where it will carry on without you.

The period of 1984 to 1990 was a time of steady growth for NRHA. As our practice grew, so did the challenge and frustration of providing good primary care to a population that was poor, sick and uninsured. The CDC Behavioral Risk Factor Survey annually finds West Virginia with high rates of smoking, obesity and inactivity. These habits translate to high rates of diabetes, premature cardiac disease and chronic obstructive pulmonary disease (COPD) in our community. The danger of work in mining and timber, combined with the lack of other good jobs, fosters dependence on compensation, Social Security and welfare for economic survival.

Because many of our patients had no insurance at all, we learned to take the patchy benefits of state and federal programs, such as family planning, cancer control, perinatal services, pediatric health services, immunizations, black lung and workers compensation, and integrate them into our regular primary care system. Hospital care was usually not a problem as long as we admitted the uninsured patients ourselves. Often we felt more like gatecrashers than gatekeepers as we got on the phone and begged for specialists to take a 14-year-old boy with a complicated fracture or a young mother with an ectopic pregnancy. Advocating for our patients became an integral part of caring for them.

We joined with the Vanderbilt Center for Health Services to establish the Maternal Infant Health Outreach Worker (MIHOW) project. Linda played a big role here. MIHOW identified and trained local women, "natural helpers," to provide in-home advocacy and support to high-risk women during pregnancy and early infancy. And when local women without private insurance found themselves virtually

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## *As a society we must decide that access is first and that no one can be left out.*

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locked out of prenatal care because of a political impasse between West Virginia Medicaid and the private obstetrics community, we envisioned a local birthing center staffed by certified nurse midwives.

All the while, our direct primary care services, home visits, in-patient hospital services, and nursing home work were growing. We also found we had a steady stream of health professions students—MD, DO, PA, NP—doing clinical rotations with us from both in-state and out-of-state schools. Clinical teaching, including teaching primary care research skills, was becoming an ever larger part of our institutional mission.

In 1990 the U.S. Public Health Service and the American Medical Student Association sponsored a conference in Washington, D.C. on community responsive practice. I was invited to speak on the role of the family physician, which made me reflect on the evolution of my values and philosophy with the NRHA over the previous 12 years of practice. I called the talk "Ten Commandments of Community Responsive Practice" (see page 50).

In preparing this talk I discovered a fundamental fact about general practice. The good general practitioner really specializes in "place." With long service, she or he acquires an intimate and practical familiarity with individuals and families, with house by house geography, and with the stores, taverns, schools, churches, and workplaces of a particular community, in addition to the endemic diseases, hos-

pitals, specialists, folk healers, drug-stores and home health agencies of that community. This is only a start. There are also the customs, religions, foods, songs, dialects, dress and so much more. And in the work of diagnosis and healing, the good general practitioner draws upon such knowledge just as much as on the universal body of medical knowledge. It is a wonderful feeling to be so at home and so needed in one little patch of Mother Earth.

The nineties have begun a new era for the NRHA, an era of mature service and regional influence. Service remains first. Staying true to that priority and demonstrating both the content and processes of real-world community responsive primary care are among the most important things we teach. We believe those are lessons for all students, not just those headed for general medicine or primary care careers.

Like most of the families in our community, the NRHA still struggles to survive financially. Limited access to financial capital is often a brake on our growth even when its direction is clear. But with 20 years of service and experience, NRHA has created a valuable store of a different kind of capital: social capital. This social capital consists of rootedness in our community, a firm and seasoned grasp of community medicine principles, a reputation for excellence in service and education, organizing skills and technical expertise that we are willing to share, and a trusted nonprofit entity able to serve as fiscal agent for new local initiatives. This social capital has been welcomed and needed throughout our state and region in this era of medical education reform, network building, and corporate buyouts. A few examples serve to illustrate.

The birthing center is now a reality. Since 1992 our three certified nurse midwives have delivered 135 babies and provided prenatal care to 1,590 women. A new 6,000 square foot birthing center is under construction

with a \$484,000 FMHA loan.

School-based health clinics have become an exciting new service area for us during this era. Medicaid statistics revealed school-aged children as a major underserved population in our county and throughout our state. NRHA obtained funding from the state and foundations to establish school health clinics in three elementary schools, three middle schools and one high school serving 912 students or 62 percent of the student population at those schools. The local school board, superintendent, school principals, PTOs and West Virginia University Department of Psychiatry have all been important partners in this effort.

That peculiar phenomenon of managed care without universal access to care has been slow in coming to West Virginia but it is finally arriving. Through our membership in the West Virginia Primary Care Association (WVPCA), and its managed care committee, our CEO Craig Robinson is leading an effort to prepare the non-profit community clinics of the state for the transition to managed care, especially the capitated Medicaid species. This has included training workshops for administrators and clinical directors, an e-mail discussion group for clinical directors, and an effort to establish a WVPCA-owned HMO with the community health centers as equity partners.

In 1991, through a competitive process, NRHA was selected as one of ten rural academic centers to make up the West Virginia Rural Health Education Partnership which grew out of a six million Kellogg grant matched with an additional six million in state funds. As this partnership succeeds in its statewide mission of community health promotion and community-based health professions education, the social capital of the whole state grows.

In some ways Dr. Gardella was right. Research and teaching can be priceless parts of a physician's career, even one destined for a career of direct patient care in a distant holler of rural Appalachia.

And yes, it is not enough to put on band-aids. For all the good work that NRHA does, our reach and impact are limited. The 600 community health centers of the U.S. are a vital part of the fraying safety net that helps to protect the poor. But we are only a bandaid on the disgraceful wound of 30 to 40 million uninsured Americans in a nation with the largest per capita health expenditure in the world.

As a society we must decide that access is first and that no one can be left out. As a profession we should insist on that social decision. And as physicians we should not rest until the gaping wound of exclusion is healed.

*Daniel Doyle '72, one of the founders of the New River Family Health Center in Scarbro, West Virginia, has worked as a family practice physician for 19 years. This past fall he was named rural physician of the year by the West Virginia Medical Association.*

## **The Ten Commandments of Community Responsive Practice**

**by Daniel Doyle**

- 1. Service is first. Thou shalt not put false priorities before this. Preach access and practice it.**
- 2. Thou shalt be a good clinical practitioner. Listen to people; respect people; be thorough; practice cost effectively; support QA; get CME.**
- 3. Thou shalt know where your patients live and who they live with.**
- 4. Thou shalt define community geographically. No one may be left out.**
- 5. Honor thy community and its right to participate in planning and decision making.**
- 6. Thou art not an expert outside thy field. Medical school made you an expert on medicine but not on architecture, finance, politics or civic affairs. In these matters community members are your peers and your teachers.**
- 7. Thou shalt take the initiative to get involved in practice planning and decision making. Don't stand on the sidelines and pout about being left out.**
- 8. Thou shalt not put work before family.**
- 9. Thou shalt be a scientist working on the cutting edge of health promotion methods and health services technologies.**
- 10. Thou shalt not panic when reading medical economics. Money is a poor measure of personal success.**





